

# Rocky Mountain Medical Journal

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## Table of Contents

VOLUME 53

AUGUST, 1956

NUMBER 8

### Editorials

|  | Page |
|--|------|
| Realistic Adjudication of Surgical Fees.....       | 699  |
| Medical Service in the Rocky Mountain Region ..... | 700  |
| Preliminary Education .....                        | 700  |

### Articles

|  |     |
|--|-----|
| Selective Spinal Anesthesia in Obstetrics, Charles E. Galt, Jr., M.D., Carlsbad, New Mexico .....  | 701 |
| The Use of Radioactive Iodinated Serum Albumin for Blood Volume Determinations, Strother B. Marshall, M.D., and Kenneth R. McKenzie, M.D., Denver..... | 704 |
| Respiratory Emergencies of the Newborn, Roy F. Goddard, M.D., Albuquerque.....   | 708 |
| Management of Diabetes During Pregnancy, E. Paul Sheridan, M.D., and Richard C. Cullen, M.D., Denver.....  | 721 |

|   | Page |
|---|------|
| Malpractice Claims in Colorado, Medical Committee, Colorado State Medical Society ..... | 727  |

### Organization

|  |     |
|--|-----|
| Colorado AMA Delegates Report.....                   | 730 |
| Program, Colorado State Medical Society..            | 733 |
| Woman's Auxiliary Program.....                       | 743 |
| Obituaries .....                                     | 748 |
| Montana  |     |
| Preliminary Program .....                            | 748 |
| Utah   |     |
| Program, Utah State Medical Association              | 750 |
| New Mexico   |     |
| Abstract of the House of Delegates Proceedings ..... | 753 |
| The Book Corner.....                                 | 768 |

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## Table of Contents

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|  | Page |
|--|------|
| Realistic Adjudication of Surgical Fees.....       | 699  |
| Medical Service in the Rocky Mountain Region ..... | 700  |
| Preliminary Education .....                        | 700  |

### Articles

|  |     |
|--|-----|
| Selective Spinal Anesthesia in Obstetrics, Charles E. Galt, Jr., M.D., Carlsbad, New Mexico .....  | 701 |
| The Use of Radioactive Iodinated Serum Albumin for Blood Volume Determinations, Strother B. Marshall, M.D., and Kenneth R. McKenzie, M.D., Denver..... | 704 |
| Respiratory Emergencies of the Newborn, Roy F. Goddard, M.D., Albuquerque.....   | 708 |
| Management of Diabetes During Pregnancy, E. Paul Sheridan, M.D., and Richard C. Cullen, M.D., Denver.....  | 721 |

|   | Page |
|---|------|
| Malpractice Claims in Colorado, Medical Committee, Colorado State Medical Society ..... | 727  |

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|  |     |
|--|-----|
| Colorado AMA Delegates Report.....                   | 730 |
| Program, Colorado State Medical Society..            | 733 |
| Woman's Auxiliary Program.....                       | 743 |
| Obituaries .....                                     | 748 |
| Montana  |     |
| Preliminary Program .....                            | 748 |
| Utah   |     |
| Program, Utah State Medical Association              | 750 |
| New Mexico   |     |
| Abstract of the House of Delegates Proceedings ..... | 753 |
| The Book Corner.....                                 | 768 |

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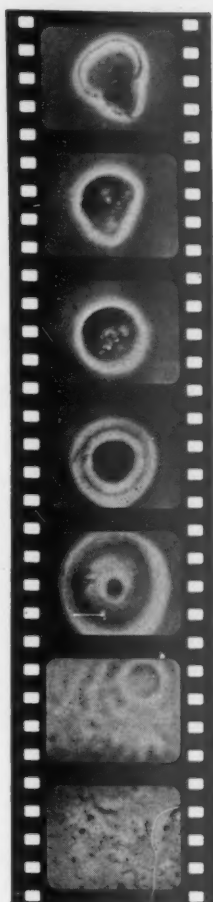
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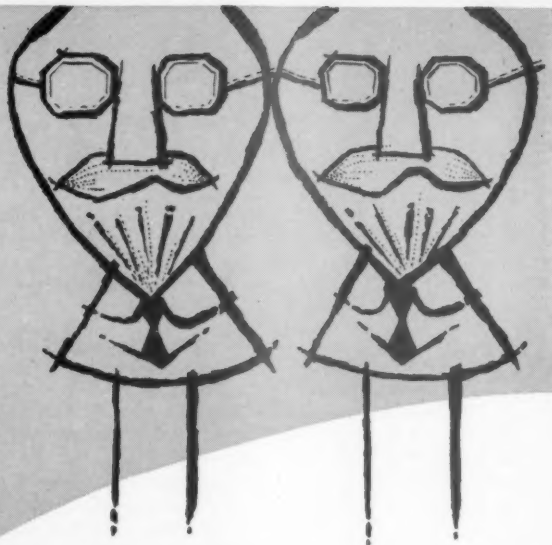


Top to bottom:

- 2 sec. CONTACTS
- 4 sec. COMPLEXES
- 6 sec. DISSOLVES
- 8 sec. DENATURES
- 10 sec. SWELLS
- 15 sec. EXPLODES
- 16 sec. SCATTERS

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1. Johnston, T. G., and Cazort, A. G.: J. Allergy 27:90, 1956. 2. Schwartz, E.: New York J. Med. 56:570, 1956. 3. Schiller, I. W., et al.: J. Allergy 27:96, 1956.

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1. Klohs, M.W.; Draper, M.D., and Keller, F.: Alkaloids of *Rauwolfia Serpentina* Benth. III. Rescinnamine, a New Hypotensive and Sedative Principle, *J. Am. Chem. Soc.* 76:2843 (1954).  
2. Cronheim, G.; Brown, W.; Cawthorne, J.; Toskes, M.L., and Ungari, J.: Pharmacological Studies with Rescinnamine, a New Alkaloid Isolated from *Rauwolfia Serpentina*, *Proc. Soc. Exper. Biol. & Med.* 86:120 (May) 1954.  
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4. Hershberger, R.; Hughes, W., and Dennis, E.: Clinical Results in the Treatment of Hypertension with Rescinnamine, *Clin. Res. Proc.* 3:71 (Feb.) 1955.  
5. Smirk, F.H., and McQueen, E.G.: Comparison of Rescinnamine and Reserpine as Hypotensive Agents, *Lancet* 2:115 (July 16) 1955.



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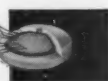
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References: 1. Boland, E. W., J.A.M.A. 160:613, (February 25,) 1956. 2. Margolis, H. M. et al, J.A.M.A. 158:454, (June 11,) 1955. 3. Bollet, A. J. et al, J.A.M.A. 158:469, (June 11,) 1955.

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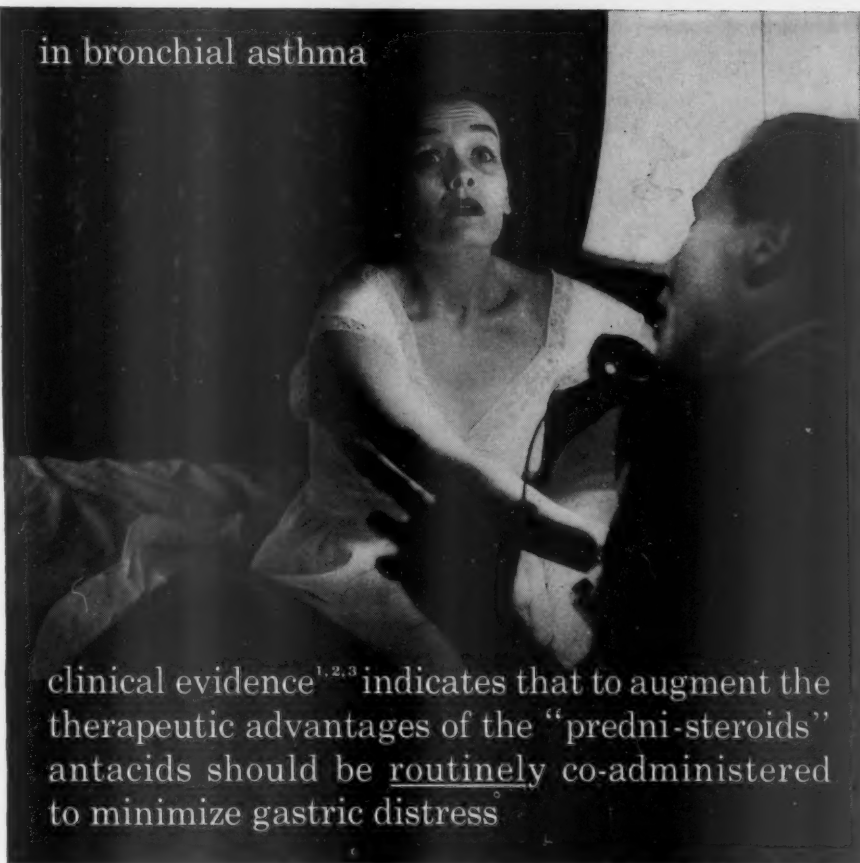
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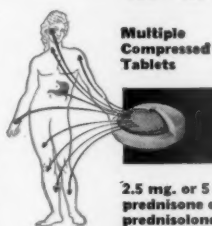
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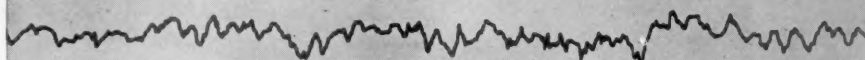
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*Comparison of the effect of Raudixin (tranquilizer) and a  
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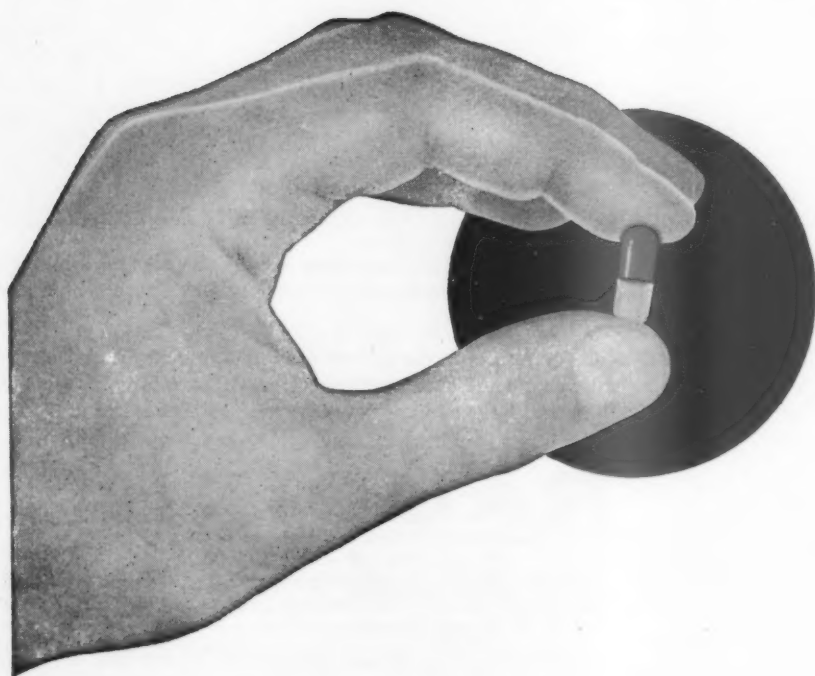


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**DOSAGE**: Four capsules (one gram) initially and then two capsules (500 mg.) twice daily.

**SUPPLIED**: 'CATHOMYCIN' Sodium (Crystalline Sodium Novobiocin, Merck) in capsules of 250 mg., bottles of 16. 'CATHOMYCIN' is a trademark of Merck & Co., Inc.

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- up to 5 times more effective than oral hydrocortisone, milligram for milligram

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*lengthens established gains*

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# METICORTEN\*

(PREDNISONE)

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METICORTEN,\* brand of prednisone. \*T.M.  
1, 2.5 and 5 mg. tablets.

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prevents postpartum hemorrhage  
speeds uterine involution



# 'Ergotrate Maleate'

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... produces rapid and sustained contraction of the postpartum uterus

'Ergotrate Maleate' almost completely eliminates the incidence of postpartum hemorrhage due to uterine atony. Administered during the puerperium, 'Ergotrate Maleate' increases the rate, extent, and regularity of uterine involution; decreases the amount and sanguineous character of the lochia; and decreases puerperal morbidity due to uterine infection.

**Supplied:**

Ampoules of  
0.2 mg. in 1 cc.  
Tablets of 0.2 mg.

**DOSAGE:** Generally, 0.2 to 0.4 mg. I.V. or I.M. immediately following delivery of placenta. Thereafter, 0.2 to 0.4 mg. three or four times daily for two weeks.

80<sup>TH</sup> ANNIVERSARY 1876 • 1956 / ELI LILLY AND COMPANY

# EDITORIALS

**M**EDICAL Directors of insurance companies and Adjudication Committees upon health and accident claims have their headaches; let's face this fact. But so, also,

## *Realistic Adjudication Of Surgical Fees*

have those of us practicing physicians and surgeons who are trying to play a fair game of ball in making the ethical Plans work! We may as well ignore the mail order, low premium, appendectomy fifty dollars, "all other operations five dollars" schemes. Also, we regret the occasional colleague who overcharges, pads his statements, and charges unnecessary assistants' fees. However, many of us are being penalized for honest efforts to conserve the funds of the better insurance organizations.

For example, one of the great companies has recently paid ten dollars against a fee of fifty—a reasonable charge for a mandatory facial reparative operation. The patient appealed to the Medical Director through the employee-representative of the corporation for which she works. Her appeal was denied, and she was told "it couldn't have been much of an operation to be only an outpatient job." Next time she needs any operation, says she, she'll go to the hospital and go to bed. And who can blame her?

Another case in point is that of a small boy who caught his right hand in a wringer and was not rescued for ten minutes. Digits were lost and deep palmar structures exposed. Amputation above the wrist could have been performed in one operation, but a valuable hand with good sensation and useful grasp was salvaged as a result of three reconstructive operations. His father pays for protection of his family against catastrophic medical, surgical, and hospital expenses by pay roll deduction in a large corporation. The insurance carrier received a fair and carefully itemized bill, but grant-

ed only the price of one operation "because less than ninety days elapsed between the surgical procedures." Incidentally, the fee allowed was the same as for a child of similar age injured in farm machinery and given maximum surgical benefit by one relatively simple operation. The father of the former is prepared to stand up and be heard the next time he and his fellow workers meet together. He will call their attention to the apparent fact that they may not receive what they are paying for when a crisis comes! Cases of honest doubt and skepticism among our patients regarding prepaid health benefits are increasing.

Despite good intentions of medical directors, fee schedules, and adjudication committees, they are missing a lot of boats in failing to "come through" upon legitimate and honest claims such as those above. Perhaps they should re-screen their participating physicians, more carefully scrutinize the itemized bills, or occasionally call patient and/or doctor personally or by phone to arrive at more just decisions in particular cases which do not and can not fit into the usual fee schedule. Outpatient work is not necessarily minor; a skilled surgeon may do more upon an outpatient, under local anesthetic, and without an assistant than an occasional surgeon in two or three hours upstairs, under general anesthetic, and with a retinue of bored attendants. Insurance carriers will find it poor economy to judge their fees by number of stitches, type of anesthesia, assistant or not, number of square inches in a graft, length of time between stages in multiple-staged procedures, and number of days in hospital. If they want to save some money, there are better ways to do it than by short-changing claims of patients with real problems, and by penalizing surgeons who shorten hospital stays, use more local anesthetics, work by themselves, and return the patient to duty at the earliest possible time!

THE Sears-Roebuck Foundation, in cooperation with the American Medical Association, has established a Revolving Assistance Fund which is making loans for improvement of

### *Medical Service in the Rocky Mountain Region*

medical facilities in areas where medical care is inadequate. Loans have gone to general practitioners, specialists, groups and partnerships for this purpose.

Many communities are desperate for adequate first-class medical and hospital care in their growing towns and territories. Public spirited citizens, churches, service clubs and other organizations have raised funds for hospital construction. They have offered other attractions for physicians and their families. In many instances there have been "no takers." This is particularly true in farming areas and the flatlands without tourists, sports, special education and other pursuits for growing families. The Executive Secretaries and central offices of State Medical organizations can provide a real service to many such communities by informing graduating interns and established physicians of the Sears-Roebuck Foundation Plan. A ten-year non-secured loan bearing zero to 6 per cent interest could be arranged upon demonstration of medical proficiency and need of the community for medical care.

Many physicians are unaware of this opportunity to improve existing facilities or to establish progressive private practice in rural or suburban communities. Its service to our profession, medical distribution, and worthy patients depends entirely upon publicizing and informing physicians of its existence.

Since the Rocky Mountain region is sparsely settled, compared with the densely populated sections of this country, the need for proper distribution of medical service is particularly great. Also communities are growing and living conditions are becoming more and more attractive to young families.

Surely the Foundation should find increasing ways and means of serving this vast section in which we live and practice. At least three Rocky Mountain physicians have received assistance under this program.

DEFECTS in public school education were recently discussed at President Eisenhower's Conference on Education. It was stated that the fundamentals of education are being neglected. Editors of Medical Journals attest this fact. An average article submitted for publication requires a lot of editing.

### *Preliminary Education*

Few medical writers know the fundamental rules of grammar—and it seems that the quality of writing, with notable exceptions, is deteriorating as the decades pass.

We are baffled by some of the changes in requirements for admission to professional schools. Such subjects as sciences, languages, and even English are being replaced by so-called "social sciences" and "humanities." Many of us would be at a loss to define what the latter subjects cover, and why should English and languages be de-emphasized? Four years of language, such as two of Latin and two of a foreign one, would provide a background finally to be reflected in superior contributions to medical literature. Deans of medical schools and Admission Committees would do well to explain the changes that have been made. A fellow editor has asked why the two words "social sciences" are such good bedfellows. He also wants definition of the term "humanities," and why does one college offer sixteen courses in "Theater" and one in Latin!

Editors of scientific journals, if not editors in general, are willing to wager that increasing, rather than decreasing, requirements in Latin and other languages, together with English, would result in greater clarity of expression, both written and spoken. Our profession is in need of improvement in both of these departments.

## Selective Spinal Anesthesia In Obstetrics\*

Charles E. Galt, Jr., M.D.  
CARLSBAD, NEW MEXICO

*Spinal anesthesia has a worthy place in obstetrics, provided it can be kept safe and free from undesirable sequela. The author feels that the ideal method is imminent.*

THE ever increasing number of spinal anesthetics employed in obstetrics indicates expanding acceptance of this method by both laity and medical profession. Outstanding indictments against this form of anesthesia have been the undesirable loss of motor nerve function, or "paralysis," and the postpartum or (less generously) post-spinal headache.

Generally, drugs interfering with conduction of nerve impulses affect sensory nerves more rapidly, and in lower dosages, than motor nerves. To introduce the proper amount of a drug at the proper rate of speed into the subarachnoid space, and achieve a concentration in the spinal fluid providing anesthesia without motor nerve impairment, previously required preparation and technics exceeding practicability. In 1947, Finer and Rovenstine reported on spinal anesthesia with piridocaine hydrochloride, remarking on the unusual latitude between the sensory and motor effects of the drug. Greene now reports more than 8,000 anesthetics with this agent, marketed under the name of Lucaine (Maltbie Laboratories, Inc., Newark, N. J.), including over 3,000 deliveries, inducing anesthesia to the level of the third thoracic dermatome, when indicated, with freedom from motor nerve impairment.

\*This paper was read at the 2nd annual meeting of District VIII, the American Academy of Obstetrics and Gynecology, at Berkeley, California, April 15, 1955.

If anesthesia can be achieved without depression of motor nerve function, then the greatest remaining impedance to the method is the postspinal headache. The multitude of investigations into this sequel now permits predicting frequency, duration, and intensity of headache, in direct proportion to size of the puncture wound left in the dura. However, rigidity of a needle is also a function of its caliber, and a cannula fine enough to penetrate the dura without permitting subsequent leakage of spinal fluid requisite for headache, cannot reliably be pushed through all tissues preceding the dura. Hoyt, in 1922, published his suggestion for the use of a relatively large bore introducer to penetrate skin, fascia, and intervertebral ligaments, and provide a splint, or conduit, for the fine gauge needle which needs then only to perforate the dura and deliver the anesthetic solution, yet leave an opening too minute for a quantitative loss of spinal fluid. Administration of Lucaine by means of the double needle technic appears to provide an ideal method of obstetric anesthesia.

When the parturient is approximately within two hours of vaginal delivery, 30 mg. of Lucaine, dissolved in 2 c.c. of 10 per cent dextrose to which has been added 1 c.c. of 1:1000 epinephrine hydrochloride, is injected in the sitting position, as a hyperbaric low spinal anesthetic. The 21-gauge introducer, a lumbar puncture needle abbreviated to half its usual length, is pushed through the

3rd, 4th, or 5th lumbar intervertebral space into, but not past, the intervertebral ligament, and the stylet removed. A 26-gauge needle, 10 cm in length, passed through the introducer, now penetrates the dura, an event usually accompanied by a characteristic, though painless, "snap." After removing the stylet, spinal fluid appears slowly at the hub. The syringe containing anesthetic solution is connected to the needle during subsidence of a uterine contraction, to avoid cephalad surge of spinal fluid occurring during this activity, and the solution is injected as rapidly as possible, the fine bore of the needle prohibiting too rapid introduction. Both needles are removed, and the patient maintained upright for an additional thirty seconds. At the end of this interval, she resumes the horizontal position as rapidly, and with as little movement as necessary.

The onset of anesthesia is subtle, appearing in from five to ten minutes. Patients seldom notice the event, but must be queried about their sensory status. There is no paresthesia or hyperesthesia such as numbness, tingling, burning, or pain along nerve distribution. When asked, the woman usually admits only that her lower extremities feel "funny" or "all gone" and while yet capable of a full range of motion she cannot tell where they are. If the parturient has had a sedative prior to induction of anesthesia, she usually drifts off to sleep.

This report covers a scant 100 cases of spinal anesthesia obtained with the drug, Lucaine. The first twelve of these anesthetics were administered through the usual 22-gauge lumbar puncture needle prior to adoption of the double needle technic. In all twelve, the anesthesia was eminently satisfactory, with no notable loss of motor power. In two of these women, the injection was repeated because, after four hours, delivery had not been effected, and the anesthesia had disappeared. No aggressive program of hydration was carried out in this group of patients, and ten of them developed headaches.

Eighty-one women were delivered under Lucaine anesthesia given through the needle-within-a-needle technic, with no notable motor paresis or subsequent head-

ache. The remaining seven merit discussion.

In three instances, lumbar puncture was inadvertently made with the 21-gauge introducer, so the anesthetic solution was forthwith given through this larger needle. Two of these women had satisfactory anesthesia, but were hydrated postpartum and headache successfully avoided. In the third instance, anesthesia failed to appear within twenty minutes, and a second puncture was made, again with a relatively large bore (22-gauge) needle. Good anesthesia was obtained, but a severe headache ensued postpartum, despite vigorous parenteral hydration.

In another two patients, anesthesia failed to appear with the double needle technic, but a second puncture with larger (22-gauge) needle provided satisfactory anesthesia for delivery. Two women were delivered under anesthesia induced through the double needle technic, then, less than twenty-four hours later, were subjected to laparotomy under the same drug, but, in both cases, the second puncture was carried out with a 22-gauge needle. Each was hydrated parenterally, as a routine post-operative measure, and neither developed headache.

### Summary

The ideal method of spinal anesthesia in obstetrics appears imminent, assuring patients that paralysis is no longer an inevitable accompaniment. Thus, physicians are relieved of undue fear of respiratory distress, and the incidence of post-spinal headache is reduced to the status of exceptional.

Difficulties with the method and, therefore, improvement fall in the realm of mechanics. Inadvertent punctures with the large bore needle cannot be debited against the procedure. However, one is compelled to speculate on equipment requiring less dexterity than that necessary to balance a 26-gauge needle within its 21-gauge introducer, without dislodging the tip from the dural sac. In contrast is the stability enjoyed with the usual lumbar puncture needle, "clutched" at any given depth of penetration by the body tissues superficial to the dura.

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a unique new antibiotic  
of major importance  
**PROVED EFFECTIVE AGAINST  
SPECIFIC ORGANISMS**  
(*staphylococci and proteus*)  
**RESISTANT TO ALL OTHER  
ANTIMICROBIAL AGENTS**



**SPECTRUM**—most gram-positive and certain gram-negative pathogens.

**ACTION**—bactericidal in optimum concentration even to resistant strains.

**TOXICITY**—generally well tolerated. This is more fully discussed in the package insert.

**ABSORPTION**—oral administration produces high and easily-maintained blood levels.

**INDICATIONS**—cellulitis, pyogenic dermatoses, septicemia, bacteremia, pneumonia and enteritis due to *Staphylococcus* and infections involving certain strains of *Proteus vulgaris*, including strains resistant to all other antibiotics.

**DOSAGE**—four capsules (one gram) initially and then two capsules (500 mg.) twice daily.

**SUPPLIED**—250 mg. capsules of 'CATHOMYCIN', bottles of 16.

'CATHOMYCIN' is a trademark of Merck & Co., Inc.



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#### Addendum

Since this report was prepared, an additional 100 anesthetics have been successfully carried out, using Luaine, and the double needle technic. The only difficulties encountered in this additional series, were

two relatively mild headaches. Discussion at the Berkeley meeting led to the omission of epinephrine from the anesthetic solution, and the almost-consistent fourth-stage vomiting, previously encountered, appeared but once in the second hundred cases.

## The Use of Radioactive Iodinated Serum Albumin for Blood Volume Determinations\*

Strother B. Marshall, M.D., and  
Kenneth R. McKenzie, M.D.

DENVER

*Determination of blood and plasma volumes is gaining acceptance in various surgical conditions as, for example, those involving hemorrhage, trauma and disturbed fluid balance. A relatively simple method is described.*

OF THE methods now in clinical use for the determination of blood volume, that of using I-131 tagged human serum albumin seems best to fulfill the requirements of speed, consistency, and accuracy. In this paper, a technic for using this method, normal values, and an example of its clinical usefulness will be presented.

The practicability of blood volume determinations became evident in 1937, when Gibson and Evans employed the azo dye T-1824 ("Evans blue") to determine plasma volume by means of the dye dilution technic. This procedure is based on the firm link of the dye to circulating albumin, and the subsequent measurement of the intravascular albumin space. Total blood volume can be determined by combining the results of this technic and the hematocrit. Intrinsic errors in this method are few, but the major drawback is that the circulating albumin becomes saturated with the dye after a few injections and further

amounts of dye are phagocytized by the reticulo-endothelial system, thus leading to false determinations. As originally described, the method is accurate for only two determinations within the space of a month.

In recent years, several technics using radioactive tracers have been developed for the determination of blood volume. Phosphorus-32, chromium-51, potassium-42, and iron-59 have all been tagged to red blood cells with results essentially similar to those of the standard Evans Blue method. These methods are cumbersome and time consuming, however, and they cannot be done on an emergency basis.

In 1950 the successful binding of Iodine-131 to human serum albumin (Cohn Fraction V) was reported by Crispell, et al. These and subsequent workers found this substance ideally suited for blood volume determinations. Human albumin contains approximately 4.5 per cent tyrosine and is readily iodinated through the tyrosyl bond. The isotope is non-toxic and has the relatively short half-life of eight days. With the highly sensitive well-type scintillation

\*From the Department of Surgery, University of Colorado School of Medicine, and the Denver Veterans Administration Hospital.

counter, amounts as small as 5 microcuries may be used for each determination. The usual tracer dose of I-131 for thyroid iodine uptake studies is 100 microcuries, an amount considered the upper limit of safety for radioactivity to the thyroid. Since only 5-10 microcuries are used on each determination of blood volume, this technic can be readily and safely repeated as many as ten times within one week.

The iodinated albumin is made from salt-free human albumin and can be purchased from Abbott Laboratories under the trade name of "RISA." Approximately 10 milligrams of albumin is iodinated with 500 microcuries of I-131, or two moles of iodine to each mole of albumin of 60,000 molecular weight. It is shipped from the laboratory in one-millicurie lots and contains less than 1 per cent free iodide. Dialysis of this material diluted to 50 milliliters with normal saline (Fig. 1) reveals a very slow liberation of the iodide for the first two weeks. Because of the rapid subsequent liberation

in the opposite antecubital vein and 8-10 ml. of blood are removed in a heparinized syringe. The blood is placed in a labeled centrifuge tube, and may be analyzed immediately or after a period of several hours, since the unknown is compared to a standard having the same decay rate. Exactly one ml. of whole blood from the centrifuge tube is carefully pipetted into a small glass counting vial. The remaining blood is centrifuged for five minutes at 3,000 rpm, and one ml. of plasma is pipetted into a similar vial. A well-type scintillation counter with an attached decimal scaler is used for measurement of radioactivity. The background count is measured first, and this value is subtracted from all subsequent calculations in order to give specific activity. One ml. of the previously prepared standard is pipetted into a third similar counting vial. Counts are then made on blood, plasma, and the standard. Blood and plasma volumes are calculated separately according to the following formula:

---

|                      |  |   |  |   |              |
|----------------------|--|---|--|---|--------------|
| Total blood volume = | $\frac{\text{counts per min. of standard}}{\text{counts per minute of blood}}$ | × | $\frac{\text{dilution of standard (500)}}{\text{counts per minute of plasma}}$ | × | ml. injected |
|----------------------|--|---|--|---|--------------|

---

|                 |   |   |  |   |              |
|-----------------|---|---|--|---|--------------|
| Plasma volume = | $\frac{\text{counts per min. of standard}}{\text{counts per minute of plasma}}$ | × | $\frac{\text{dilution of standard (500)}}{\text{counts per minute of plasma}}$ | × | ml. injected |
|-----------------|---|---|--|---|--------------|

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of free iodide, each quantity of the "RISA" can be used for two weeks only.

#### Technic

The commonly employed one-millicurie shipment (approximately 1 ml.) of albumin is diluted to 50 ml. with normal saline, giving an initial dosage of 20 microcuries per ml. One ml. of the diluted albumin is carefully diluted to 500 ml. in a volumetric flask for preparation of the standard. For each determination, one-half to one ml. of the iodinated albumin (5-10 microcuries) is drawn into a calibrated tuberculin syringe and injected into an antecubital vein. The syringe is then routinely "washed out" by withdrawing blood and pushing back into the vein. Ten to twelve minutes after injection a venipuncture is performed

The red cell volume can be determined by subtracting the plasma volume, and the hematocrit by dividing red cell volume by total volume.

To avoid errors, an exact amount of iodinated albumin must be injected and exactly one ml. of the blood and plasma must be counted. Care and experience reduce these problems to a minimum. To run repeat determinations on the same patient, a sample of blood is withdrawn immediately prior to the injection of the second dose of albumin and the activity of this specimen is subtracted from the count of post-injection specimen. The entire procedure takes about thirty minutes.

#### Normal Values

A group of thirty hospital nurses and

thirty pre-operative male patients not suffering from evident derangement of blood volume were selected. The latter were ambulatory patients on the surgical service admitted for minor procedures. The average age for the males was 39.8 years, and for the females 29.7 years. Each subject was weighed (actual weight), questioned closely for his usual weight, and measured to determine his "ideal weight" (based on Metropolitan Life Insurance tables for age and height). Determinations were performed after a minimum of four hours' fast for each normal subject. Mean values with standard deviation were calculated for the male and female groups. A summary of the normal values is given in Table 1.

Blood and plasma volume determinations based on the normal subjects' actual weight were compared with those recorded in Denver by the Evans Blue method and with the volume measurements at lower altitudes, utilizing both the iodinated albumin and dye methods. Normal values in these four studies are presented in Table 2. The mean normal values for both total blood volume

and plasma volume are strikingly similar, all within one standard deviation of each other.

As has been noted by others, it was found in this study that blood volume is decreased in obese and stocky individuals. Conversely, in extremely thin subjects blood volume measurements were usually higher than the mean. The ideal weight seems to be a better standard for evaluating blood volumes in the obese, while in subjects with recent gain or loss in weight the usual weight is best used.

#### Use of the Method

Blood volume measurements are gaining widespread clinical acceptance in a variety of surgical conditions. These absolute values are most helpful in pre-operative and post-operative evaluation and management of surgical patients in whom oligemia may be suspected, as well as in emergency situations involving hemorrhage and trauma. In burns, fluid therapy can be simplified by blood volume determinations, which can be performed hourly if the radioactive iodinated albumin technic is employed. The

TABLE 1

|                         |               | Male             | Female           |
|-------------------------|---------------|------------------|------------------|
| Blood volume based on:  | Actual weight | 71.2 ± 8.3 cc/kg | 72.4 ± 7.1 cc/kg |
|                         | Usual weight  | 69.0 ± 6.4 cc/kg | 71.8 ± 6.5 cc/kg |
|                         | Ideal weight  | 71.0 ± 6.2 cc/kg | 69.7 ± 4.7 cc/kg |
| Plasma volume based on: | Actual weight | 37.2 ± 4.2 cc/kg | 40.9 ± 4.0 cc/kg |
|                         | Usual weight  | 36.1 ± 3.7 cc/kg | 40.5 ± 3.8 cc/kg |
|                         | Ideal weight  | 37.2 ± 3.9 cc/kg | 39.4 ± 3.3 cc/kg |
| Hematocrit              |               | 47.6 ± 3.0       | 43.5 ± 3.0       |

TABLE 2

| Determinations by the Evans Blue Method        | Sea Level (Hartford, Conn.) | Blood Volume  | Male 76.8 cc/kg  | Female 68.6 cc/kg |
|--|-----------------------------|---------------|------------------|-------------------|
|  |                             | Plasma Volume | 42.5 cc/kg       | 40.4 cc/kg        |
| Determinations by the Iodinated Albumin Method | Denver (Fitzsimons)         | Hematocrit    | 44.7             |                   |
|  |                             | Blood Volume  | 77.6 cc/kg       |                   |
|  |                             | Plasma Volume | 39.9 cc/kg       |                   |
| Determinations by the Iodinated Albumin Method | Sea-Level (Cleveland, Ohio) | Hematocrit    | 48.6             |                   |
|  |                             | Blood Volume  | 74.3 ± 8.7 cc/kg |                   |
|  |                             | Plasma Volume | 40.3 ± 4.2 cc/kg |                   |
| Determinations by the Iodinated Albumin Method | Denver (Present Study)      | Hematocrit    | 45.8             |                   |
|  |                             | Blood Volume  | 71.2 ± 8.3 cc/kg | 72.4 ± 7.1 cc/kg  |
|  |                             | Plasma Volume | 37.2 ± 4.2 cc/kg | 40.9 ± 4.0 cc/kg  |
| Determinations by the Iodinated Albumin Method | Denver (Present Study)      | Hematocrit    | 47.6 ± 3.0       |                   |
|  |                             | Blood Volume  | 71.2 ± 8.3 cc/kg | 72.4 ± 7.1 cc/kg  |
|  |                             | Plasma Volume | 37.2 ± 4.2 cc/kg | 40.9 ± 4.0 cc/kg  |

degree of blood and fluid loss can be estimated at any moment, rather than depending on the less accurate and occasionally misleading hemoglobin and hematocrit determinations.

The potential value of blood volume determinations in postoperative management was emphasized by the study of Forsee, et al. In a group of thoracic surgical procedures, every attempt was made in the operating room to measure blood loss, by weighing sponges, drapes and towels, and by measuring all suctioned fluid. These crude estimates of blood loss during the operation were compared to the blood loss as calculated by the Evans Blue method, and it was found that 50 per cent more blood was lost in most cases than could be accounted for in the operating room.

The following case of trauma is presented as an example of the clinical usefulness of measuring blood and plasma volume by this method.

#### CASE REPORT

R. F., a 32-year-old white male, was admitted to the neurosurgical service of the Colorado General Hospital on April 6, 1955, following an automobile accident. He had multiple severe contusions and a compound skull fracture. An iron spike had been driven into the parietal region, and he was comatose and in respiratory distress on admission. A tracheotomy relieved the respiratory difficulty. His blood pressure was 100/60 on admission and remained at this level throughout the debridement, which was begun four hours after he reached the hospital.

His initial hematocrit was 51 per cent. During the operative procedure he received 500 ml. of 5 per cent glucose and 2,000 ml. of whole blood, which was thought to be more than adequate to replace blood loss. Immediately postoperatively, his blood pressure remained at the same level, and his hematocrit was 42 per cent. His pulse, however, was thready at 140-160 per min. Blood volume determination at this time revealed a total volume of 2,880 ml. Estimated weight was approximately 180 lbs., and estimated normal blood volume was 5,700 ml. His immediate deficit, therefore, was approximately 2,820 ml. Over the next twelve hours, he was given 2,000 ml. of blood. His pulse gradually returned to 80-90 per minute. His hematocrit two days later was 40 per cent, and his blood volume 5,200 ml. His clinical condition improved as his oligemia was corrected by multiple transfusions. The remainder of his hospital course was uneventful.

#### Summary

1. A relatively simple method of determining blood and plasma volumes by means of radioactive iodinated human serum albumin has been described.

2. The method has been used in establishing normal values from a group of thirty males and thirty females in apparent good health. The results have been compared to normal values reported by other authors in regard to the method employed and the locale.

3. The importance of blood volume determinations in the management of the surgical patient has been stressed, and a case has been presented wherein its use proved of great clinical value.

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#### STATE MEDICAL JOURNALS

It has been predicted from time to time that state medical journals are doomed to die, because eventually they will have no scientific function. There are those who have expressed the belief that special journals and other media such as television and radio may usurp so much of the present educational function of our state medical journals that there will be no place for them. State medical journals are assuming a place of greater rather than lesser importance.

Let us define some of the prime functions of a state medical journal. To the physician there are, in order of their importance: the publication of scientific articles on medical subjects in general; those of a newspaper dealing in news of special interest to physicians; a means of communication between members, committees, of-

ficers, and governing bodies and, not the least important, advertising, chiefly pharmaceutical. . .

When one considers the advertising angle, the first axiom is that the volume of advertising will closely parallel the reader-interest of the publication. In other words, the advertiser will not spend his money unless he believes the people he wants to reach are reading the journal and, consequently, reading his ads. The fact that the advertiser is buying more space and using more expensive spreads is substantial evidence that he believes the state medical journals are gaining popularity.

The prediction of the death of our state medical journals by slow starvation cannot be foreseen at this time. They are, on the contrary, in their ascendancy.—Nebraska State Medical Journal.

# Respiratory Emergencies Of the Newborn\*

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*An exhaustive discussion of the appalling death rate, among the newborn, from conditions present at birth and from pathologic conditions developing in the neonatal period.*

**A**PPROXIMATELY 150,000 deaths, or one-tenth of the total number occurring in the United States annually from all causes

\*Presented before the 52nd Annual Meeting of the Nevada State Medical Association, with the 6th Annual Conference of the Reno Surgical Society, Reno, Nevada, August 18, 1955. The author is Director, Pediatric Research Department, Lovelace Foundation for Medical Education and Research.

and at all ages, are infants who die in association with the birth process. This appalling infant mortality rate presents one of the outstanding problems in preventive medicine today, particularly since the last forty years have brought no significant reduction in infant deaths in the first day of life. Bundesen has recently estimated that over two-thirds of these needless

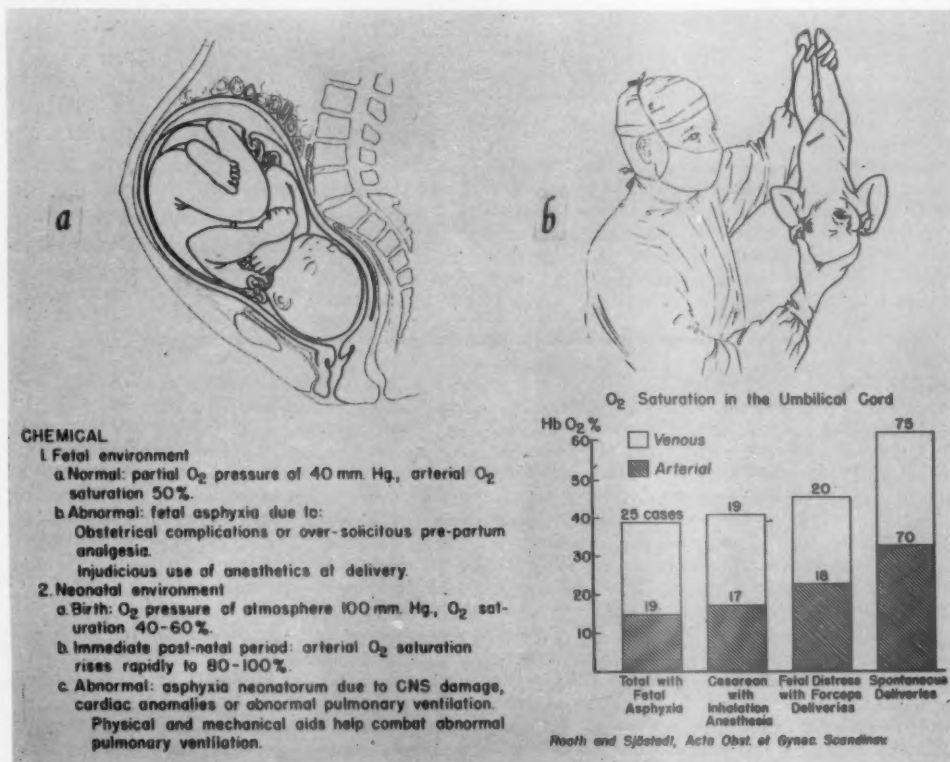


Fig. 1. Factors influencing neonatal respiration.

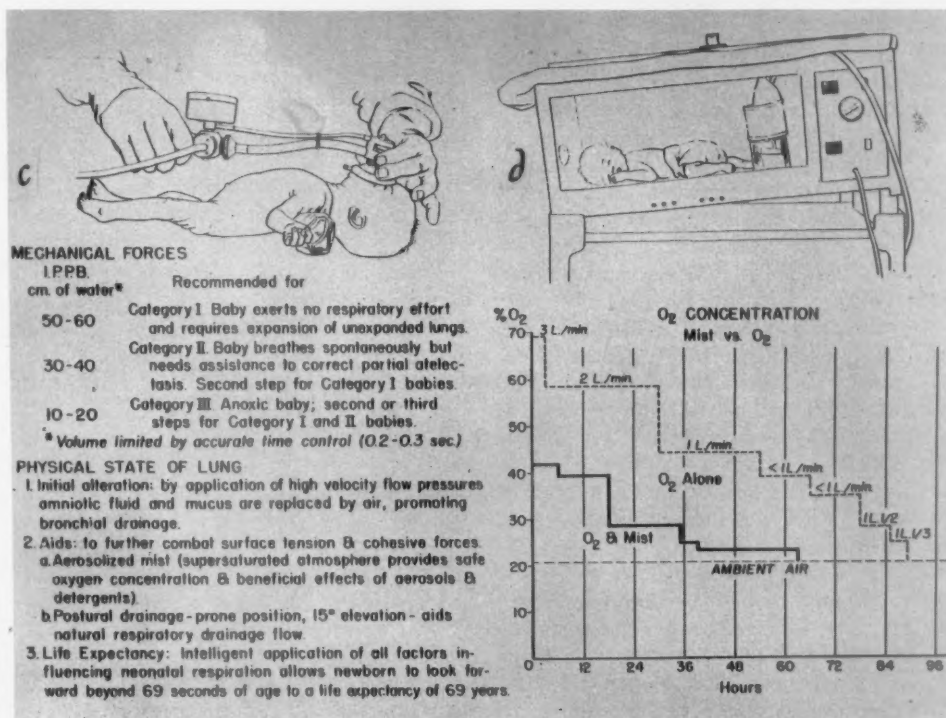
neonatal deaths can be attributed to inadequate respiratory exchange (anoxia and abnormal pulmonary ventilation), and that the remaining causes may contribute to pulmonary embarrassment. We believe these main respiratory problems can best be divided into those conditions present at birth and those developing in the neonatal period.

#### Conditions Present at Birth

1. Anoxia: The fetus in utero lives in an oxygen environment corresponding to the atmosphere at 33,000 feet (three-quarters of a mile above the summit of Mt. Everest). Here the baby's partial oxygen pressure is 35 to 40 mm. (Fig. 1a) Hg, and his arterial oxygen saturation is roughly 50 per cent of his total capacity. Further insult by way of obstetrical complications, over-solicitous use of pre-partem analgesics, and injudicious use of anesthetic agents for delivery reduces this oxygen saturation dangerously low and we are confronted with fetal distress, as evidenced by cessation of fetal movements and a faint rising or falling, or inaudible, fetal heart beat. Such evidence of fetal

anoxia calls for immediate delivery in the hope of salvaging the baby. Prolonged labor, cesarean section and the use of forceps offer further hazards and should be avoided where possible. Normally, at the time of birth the infant changes his environment to our atmosphere with an oxygen pressure of 100 mm. Hg, and, although his oxygen saturation at birth may only be 40-60 per cent, it rises rapidly to 80-100 per cent (Fig. 1b).

The anoxic newborn may have a delay in respiratory onset; if respirations are present, they are usually weak, irregular, accompanied by a series of irregular gasps without a true expiratory component and frequent periods of apnea. Varying degrees of cyanosis are present, together with atonia and shock, with no response to cutaneous stimuli and decreasing response to drugs. The heart beat is usually slow and very irregular. Clinical signs of an excessive amount of amniotic fluid and debris may be present with evidence of bronchial obstruction and atelectasis. These



symptoms closely simulate those associated with respiratory disturbances of central origin and may be primarily the result of cerebral anoxia rather than pulmonary pathology.

Whether the cause of the anoxia be central or peripheral in origin, the treatment starts with the establishment of a patent airway, followed by the administration of oxygen. N-allyl normorphine (nalline) may be of some value in counteracting central depression due to morphine or its derivatives if a good heart beat is present. The lungs offer the most efficient surface for oxygenation of the blood, and once regular rhythmical impulses from the respiratory center have started, the infant usually expands his own lungs effectively thereafter.

Intermittent positive pressure-oxygen therapy by mask usually affords sufficient arterial blood oxygenation to induce this sequence. Mask pressures of 25 to 30 cm. water, repeated ten to twenty times at five-second intervals, followed by pressures of 20 cm. repeatedly over five to ten minutes usually suffice.

**2. Abnormal Pulmonary Ventilation:** Although the entire list of problems under discussion influence pulmonary ventilation, two pathologic entities contribute most to this condition: (1) the unexpanded lung of the infant who has never breathed, and (2) atelectasis, either the segmental type present at birth, or the resorption type which develops in the neonatal period in association with hyaline membrane disease.

a. **Unexpanded lung.** Considerable progress has been made in studying this problem during the past two decades. The demonstration by Wilson and Farber in 1933 that positive water pressures greater than 25 cm. were necessary to expand the lungs of newborns and the brilliant work of Smith and Chisholm in 1942 to show that the newborn, in struggling for a breath, produced inflating pressures in excess of 40 cm. of water, led to the development of the "Day impulse principle." Simply stated, this principle was that "a certain minimum pressure must be exerted to correct atelectasis; to employ this pressure safely, its

duration must be limited to a time interval, simulating an infant's initial inspiratory gasp." In 1952 Day, et al., proved the validity of this hypothesis in animal studies. In this same year our Pediatric Research Department undertook further laboratory and clinical studies of this problem, and in 1953 was able to show (1) that beginning patchy aeration of the unexpanded lung of the human newborn was achieved with a positive pressure of 30 cm. of water; (2) uniform expansion was achieved at pressures of 50 to 60 cm. in the closed chest; and (3) 0.2 to 0.3 of a second is a safe time interval over which such high pressures can be applied safely (Fig. 2). Tidal volume and compliance studies showed that two to three times the tidal volume could be introduced into infant lung under pressure without damaging the lungs.

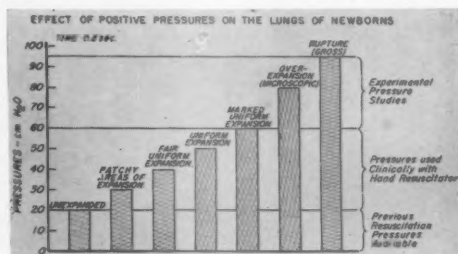


Fig. 2. Effect of positive pressures on the lungs of newborns.

The clinical picture of the infant who has exerted no respiratory effort is one of cyanosis, atonia, circulatory collapse, and no response to reflex irritation. Without immediate attention this infant rapidly succumbs, or is called a stillbirth by many, or, if he survives, may go on to cerebral palsy or other more severe neurologic conditions due to the cerebral anoxia he may suffer at this time. Therapy should follow certain basic principles of resuscitation: (1) establish a patent airway by gentle nasopharyngeal suction with the infant slanted downward (10-15 degrees) and the head hyperextended by use of a pad or diaper under the shoulders, (2) expand lungs by intermittent positive pressure, (3) promote adequate drainage by intermittent suction to keep airway clear of mucus and secretions, maintain postural drainage, (4) administer

oxygen (up to 40 per cent) where indicated, (5) maintain temperature and humidity, (6) gastric lavage when indicated (premies, cesarean sections, diabetics, any baby with evidence of an excessive amount of amniotic fluid and debris), and (7) stimulants when indicated—chemical and cutaneous or proprioceptive. The first step should be accomplished immediately; if the baby's condition does not improve within two minutes of birth, positive pressure should be applied. To effectively achieve expansion, initial resuscitation should start with the application of a positive water pressure of 50 to 60 cm. Such a pressure can be safely applied over a 0.2 to 0.3 second interval when given via the GBL (Goddard-Bennett-Lovelace) Infant Hand Resuscitator (Fig. 1c). Twelve to twenty-four impulses are given in the first minute of resuscitation, allowing an expiratory interval of 0.4 to 0.8 second in order that full exhalation occurs and circulatory return is not impeded. The baby should then be suctioned to remove the mucus, meconium, and amniotic fluid replaced in the respiratory system by the oxygen administered under high pressure, high velocity flow rates. Following initial resuscitation at these high pressures, the lungs usually show some amount of expansion and the infant takes a breath. (Frequently one or two impulses may be sufficient to initiate respiration.) Once satisfactory expansion and voluntary respiration is achieved, the pressure should then be reduced to 40 cm. for another twelve to twenty-four impulses, followed by further suctioning, and finally the pressure can be decreased to 20 to 30 cm. of water after the infant has established good respirations. The rate of positive pressure impulses should be guided by the operator, who should synchronize his impulses with the infant's efforts to breath. Usually the infant who responds to intermittent positive pressure resuscitation will do so within the first twenty minutes; failure to do so frequently indicates intracranial hemorrhage or congenital cardia. If a patent airway is initially achieved and maintained, expansion can be achieved via a face mask and thus minimize the dangers associated with intratracheal

suction and insufflation. Where absolutely necessary, tracheal intubation should be performed initially and correctly without repeated manipulations.

b. Segmental atelectasis. Segmental or partial atelectasis denotes small segments which have either failed to expand or once expanded have collapsed and become atelectatic. Frequently associated pulmonary pathology such as bronchial obstruction may be present, and in many instances intracranial pathology can be demonstrated at postmortem examination.

In some infants only slight respiratory distress may be present, with minimal retraction of the upper chest. Auscultation may be of little value as far as breath sounds are concerned, but will indicate the circulatory status, together with the color of the child. Other infants may have marked retraction with "see-saw" asynchronous movements of the chest and abdomen. Here the respiratory rhythm is irregular and tidal volume exchange may vary from breath to breath. Auscultation may reveal absent breath sounds, either generalized or spotty in character. X-rays of the chest may show normal expansion, large or small segmental areas of atelectasis, or maximal partial or lobar atelectasis.

Treatment should be based on the infant's clinical condition, not on physical or roentgenographic signs. If his respiratory exchange and consequently his circulatory and cerebral status are encroached upon, intermittent positive pressure-oxygen therapy should be given without delay. Since the infant has breathed on his own, pressures of 30 to 40 cm. usually suffice. Once the infant shows response to resuscitation, the pressures can be even further reduced to 20 to 30 cm. Subsequent periodic intermittent positive pressure resuscitation is based on the clinical course and improvement in physical and roentgenographic findings. There should be no hesitation to resuscitate at these pressures a baby who shows any degree of respiratory distress.

c. Resorption atelectasis and the hyaline membrane syndrome. About one-third of the infants dying as a result of abnormal pulmonary ventilation suffer from hyaline

membrane disease. Pulmonary hyaline membrane is the most frequent significant pathologic finding in premature infants, but may be seen frequently in infants born by cesarean section, infants of diabetic mothers, infants of toxemic mothers, and infants subjected to intrauterine distress or asphyxia (occasionally may be seen in apparently normal pregnancies and deliveries).

Whatever the cause, we know that the membrane is not seen pathologically unless extrauterine respiratory movements have persisted over a period of at least one hour. In about one-half of the infants who go on to develop the membrane, symptoms may manifest themselves at the time of delivery. In the remaining one-half the respiratory distress begins minutes to hours after birth. Rapid respirations progress to grunting and dyspnea, retraction and cyanosis. Inspiratory and expiratory difficulty is evidenced by increasing thoracic (suprasternal, intercostal and xiphoid) and abdominal retractions; the respiratory rhythm is irregular with poor respiratory exchange (tidal volume) and is variable from minute to minute, hour to hour; the pattern of breathing rapidly becomes one of an asynchronous "see-saw" sinking of the upper chest as the abdomen rises. In spite of vigorous respiratory movements, auscultation of the chest while the infant is not crying usually reveals little or no apparent exchange of air. There may be dullness in a given area; one hour later hyperresonance may be present. The occurrence of such symptoms at or shortly after birth is strong presumptive evidence of the presence of pulmonary hyaline membranes. X-rays of the chest may offer confirmatory support, since they show a characteristic diffuse, fine, reticular pattern throughout the lung fields with moderately to markedly increased density (Fig. 3).

Prophylactically, intrauterine distress, prematurity and section should be avoided when possible. Active therapy includes maintenance of an adequate airway, frequent nasopharyngeal aspiration, gastric lavage, postural drainage, periodic intermittent positive pressure as indicated, oxygen-

mist environment, adequate control of temperature and humidity, avoidance of feeding during periods of respiratory distress and the liberal use of antimicrobials to treat any coexisting bronchopneumonia (due to aspiration or infection).

d. Post-resuscitative measures. The basic principles of resuscitation have been mentioned, together with a discussion of intermittent positive pressure resuscitation. Post-resuscitation measures should include: (1) continue principles of resuscitation as indicated (postural drainage, intermittent positive pressure, oxygen, temperature, stimulants), (2) high humidity through water fog or mist incorporating detergents and aerosols, (3) avoid regurgitation and aspiration (nothing by mouth, hydration through mist therapy and hypodermoclysis), (4) prevent infection (intramuscular and aerosol medications), (5) prevent hemor-



Fig. 3. Reticulo-granular x-ray pattern seen in hyaline membrane syndrome.\*

\*X-ray of 1786 gm. premature infant with clinical signs of hyaline membrane syndrome, age 12 hrs. Diagnosis confirmed at autopsy, death age 60 hrs.

rhage (vitamin K), (6) conserve infant's energy (minimum handling), and (7) gradual adjustment to normal infant routine.

Postural drainage is important in maintaining an adequate airway and in promoting adequate drainage of pulmonary as well as upper respiratory secretions. To provide the assistance of gravity, the prone position on an inclined plane of about 15 degrees with the horizontal has been advocated (Fig. 1d). The theoretical advantages of hypothermia in lowering metabolism are probably less in newborns with unexpanded lungs than in the older patient whose lungs have been in use. Therefore, it is recommended that incubator temperatures be set at 30-32° C (or maintenance of incubator temperature around 90° F), and that an attempt be made to keep the baby's temperature between 96-98° F. Chemical stimulants (nalline, caffeine Na benz.) are of value in CNS depression only if the circulation is adequate. Proprioceptive stimuli, including rocking, may be of value if complete cessation of respiration has not occurred. Vitamin K should be given for its possible value in increasing capillary resistance. Minimum handling and gradual adjustment should be standard procedures in any newborn nursery.

The question of oxygen has become foremost in discussions of care of the newborn, since establishment of the unquestionable relationship between oxygen concentration and the production of retrolental fibroplasia. Forty per cent oxygen concentration has now been set as the critical safe level. Oxygen should continue to be used where indicated in the cyanotic infant, with the following provisions: (1) thorough indoctrination of medical and nursing staffs on dangers in overusage of oxygen; (2) except for emergency use, oxygen therapy should require a specific order, and should be ordered by concentration rather than by flow rate; (3) oxygen concentrations should be measured and recorded q. 8 h.; (4) oxygen withdrawal should be gradual in progressively decreasing amounts. Such careful scrutiny in oxygen therapy necessitates the presence of an oxygen analyzer (Beckman, or other)

which today should be considered standard equipment in every newborn nursery.

As to the role of humidity in this post-resuscitative period, several factors are of importance. Insensible water loss from the respiratory tract of the newborn is considerable and this becomes of even greater importance in those with respiratory distress. Without the maintenance of humidity there is a drying up of the entire respiratory system, allowing concentration of thick, sticky secretions which may impede the normal function of the ciliated epithelium, and eventually may lead to bronchiolar obstruction, followed by progressive atelectasis and the development of infection in these obstructed and non-aerated areas. Recent studies have shown that insensible water loss from the lungs is reduced some 80 per cent by employing a supersaturated atmosphere, and that this associated economy in body water is in most cases sufficient to prevent the hemo-concentration normally occurring about seventy-two hours after birth. With the small size of the alveolus of the newborn, the difficulty in expanding the newborn's non-expanded lung, and the role of surface tension in the interface between contacting mucous membranes, together with the cohesion of moist surfaces of the air passages, we believe every effort should be made to maintain expansion of the lungs, once that expansion has been achieved. In order to reach the very small alveoli of the newborn, microscopic droplets (1 to 3 microns in diameter) must be obtained. This can be achieved by a number of nebulizers (Mist-O<sub>2</sub>-Gen, Hi-Flow Nebulizer, Penisol, Vaponefrin), and to fine clouds or mists useful aerosols can be added. Detergents (Alevaire, Triton-A-20) are of value because their wetting action speeds liquefaction of aspirated material (mucus, blood, amniotic fluid, caseom vernix) and their emulsifying properties assist in breaking up mucus deposits, loosening purulent exudates, and possibly in emulsification of the protein-like hyaline membranes. In addition, they reduce surface tension, and this is important where cohesion of moist surfaces of the air passages is a force resisting aeration of atelectatic lung tissue. They potentiate

the action of some of the newer antibiotic agents, which becomes of importance where superimposed infection outweighs obstruction. Penicillin, streptomycin, and terramycin aerosol solutions have been most frequently employed with apparent benefit. Glycerine helps to delay the evaporation of mists, permitting the droplets to reach deep into the bronchopulmonary tree. Denton advocates the use of bronchovasoconstrictors (neosynephrine, ephedrine) to reduce local edema of the mucous membranes. We believe any infant with an evidence of respiratory distress has some degree of bronchospasm and have found the use of bronchodilator aerosol solutions (Isuprel, Vaponefrin) helpful in maintaining a patent airway. In a rare case with thick tenacious secretions, the enzyme Tryptar has been given directly under positive pressure into the respiratory system with dramatic liquefaction of secretions. Because of irritant qualities, the method, duration, and frequency of administration must be carefully planned.

We believe that the most effective therapy in this post-resuscitative period is combined oxygen-aerosol therapy. Recent studies show that a simple aerosolized mist (composed of Alevaire 100 c.c., distilled water 200 c.c., Isuprel 1/200 solution 1 c.c.) when generated by given oxygen flow rates provides a safe supersaturated atmosphere with an oxygen concentration well below 40 per cent now recommended (Fig. 1d).

#### **Congenital Anomalies, Intracranial Hemorrhage, and Pathology Developing in Neonatal Period**

Many conditions other than anoxia and abnormal pulmonary ventilation causing respiratory distress in the newborn are an emergency and warrant our attention.

1. **Congenital Anomalies:** Among the anomalies which may involve the upper respiratory tract are cleft palate, laryngeal webs, vascular rings and anomalous vessels, congenital goiters, and congenital absence of the tracheal rings. Varying degrees of respiratory distress are present in these conditions, the most severe type being encountered in infants who have incom-



Fig. 4. Severe respiratory distress in premature infant with incomplete tracheal cartilage rings.\*

plete formation of the cartilaginous rings of the trachea (Fig. 4). In this latter condition severe sternal retraction occurs, and the tidal volume exchange is insufficient to maintain life. In addition to the clinical findings present in these conditions, roentgenographic examination may be of considerable benefit. Surgery is usually helpful in all but this latter tracheal anomaly. Occasionally we see partial or total pulmonary agenesis which is an irreparable problem. Deficiencies and anomalies of the anterior thoracic wall are to some extent amenable to surgery. Probably the two most important and frequent reparable conditions associated with respiratory anomalies are the tracheo-esophageal fistula and the diaphragmatic hernia.

a. **Tracheo-esophageal fistulas.** Three main types of anomalies may occur: (1) complete absence of the esophagus—rare, (2) atresia without tracheal fistula, and (3) atresia with tracheo-esophageal fistula. The majority fall into this last type and can be further subdivided into (a) fistula between upper segment and trachea, (b) fistula between lower segment and trachea, and (c) fistulas between both segments and trachea (Fig. 5).

Little evidence of any difficulty is pres-

\*Premature infant, age 4 days, respiratory distress and thick, copious mucous secretions. Intermittent positive pressure combined with Tryptar aerosol therapy given via the GBL Infant Hand Resuscitator improved the tidal volume exchange temporarily, but infant died at age 19 days and autopsy revealed: (1) incomplete tracheal rings, (2) small esophageal hiatus hernia, and (3) small reduplication of stomach at esophagus-cardia junction.

DIAGRAMMATIC SKETCHES SHOWING TYPES OF ATRESIA

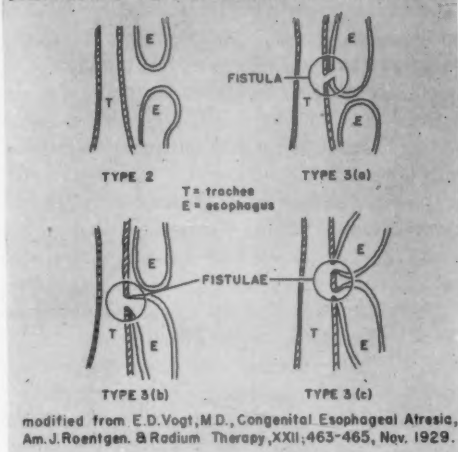


Fig. 5. Types of tracheo-esophageal fistulas.

ent at birth except for an increased amount of pharyngeal mucus and secretions. During the first twenty-four hours cyanotic spells may become frequent, associated with the appearance of considerable frothy mucus in the mouth and nose. Real trouble begins with attempted feeding, resulting in immediate regurgitation of fluid accompanied by alarming respiratory distress; if attempts to feed the baby are persisted in, aspiration pneumonia rapidly develops, and at the same time the baby becomes dehydrated. If the fistula between the trachea and lower segment is large, air passes down through the lower segment into the stomach and results in distention of the small intestine. The child may pass meconium in the first day or two, but this is usually small in amount.

Diagnosis is verified simply and safely by passing a small catheter into the esophagus. The catheter usually meets obstruction at the level of the thoracic inlet. Fluoroscopy verifies the position and lipiodal can be injected safely to outline the site and extent of the deformity (barium should be avoided here, as the contrast media almost always overflows from the upper pouch into the lungs). Fistula between lower segment and trachea is present in approximately 80 per cent of the cases, and therapy can safely be started on that assumption

Three conditions must be met to save the baby: (1) secretions from the mouth and nose, which cannot be swallowed, must be prevented from overflowing into the trachea, (2) gastric contents must be prevented from passing upward through the esophagus into the lung through the fistula, and (3) provision for feeding must be made. Pre-operatively, the principles for handling respiratory problems as outlined previously (incubator, mist, oxygen, postural drainage, intermittent positive pressure, suction PRN, antibiotics), should be followed. The baby should not be fed, but maintained by respiratory hydration and hypodermoclysis (limit parenteral fluids to 100 c.c./kg. to prevent edema of operative tissues). Urine and stools should be charted, and a blood count and type and cross match done. Surgery should be performed early, before respiratory failure develops due to flooding of the lungs with mucus and aspirated material. It is important that surgical repair be performed by a surgeon familiar with handling the small and friable tissues of infants. Postoperatively, the infant should be initially maintained again by respiratory hydration and parenteral fluids, given slowly to guard against overhydration and nitrogen retention. Gastrostomy is usually delayed four to five days after the first procedure to allow sufficient healing of the upper end of the lower esophageal segment so that regurgitation into the wound is avoided, and also to allow an adequate period for subsidence of aspiration pneumonia. The chest should be checked periodically by x-ray to determine any leakage; if this occurs, feeding should be by gastrostomy. The day after gastrostomy feedings are started a rapid advance from clear fluids to evaporated milk formula in two to three-hour small feedings can be made. When the infant begins to gain and develop, oral feedings can be started. In the case of a direct anastomosis, oral feedings may start as soon as one week after operation. Monthly visualization of the new tract is recommended, with dilatation as necessary.

b. Diaphragmatic hernia. Fortunately,

the incidence of this anomaly is low, but when it is present it constitutes a dire emergency. The three main sites of diaphragmatic herniation occur at the: (1) postero-lateral portion (foramen of Bochdalek most common site, three to four times more common on left than on right), (2) esophageal hiatus, and (3) retrosternal area (foramen of Morgagni least common site).

Clinical findings may be referable to the respiratory, circulatory, or digestive systems; severity of the symptoms is dependent upon the number of abdominal viscera displaced. Cyanosis may be present immediately at birth, it may be transient and appear only during nursing or crying, or it may be constant, requiring oxygen and the respiratory therapeutic measures to maintain life. Occasional relief may be achieved by turning the baby so that the side of the hernia is downward. Dyspnea, with rapid, shallow breathing is usually present. Vomiting may occasionally follow feedings, and there is usually poor weight gain or even weight loss. The pulse and respiratory rates are increased, the baby is usually dusky or cyanotic, with respiratory distress. The affected side of the thorax may move less than the normal side, the trachea is usually deviated to the right, and the heart can be percussed to the right of the sternum. The left chest is tympanitic on percussion; occasionally peristaltic tinkles may be heard; breath sounds are absent over the entire left chest, and scattered in nature on the right. The abdomen has a scaphoid appearance—small in proportion to the remainder of the body; no organs or masses are palpable.

Usually an AP film of the chest is sufficient to establish the diagnosis. The unaffected side shows poorly expanded lungs with heart and mediastinal shift; the affected pleural cavity contains viscera continuous with abdomen. (Barium studies of the GI tract are unnecessary and should not be done, as danger of vomiting and aspiration pneumonia exists). Surgery should be done within forty-eight hours. Again pre-operative measures should be directed around sustaining life—respiratory, circulatory, digestive (oxygen, hydration,

deflation of alimentary tract — enemas, gastric suction). Two surgical approaches have been used: (a) thoracic and (b) abdominal. In the latter, caution should be used not to over-anesthetize when sewing up, as cardiac and respiratory arrest seem to be a frequent complication at the time of operation. Postoperative care includes respiratory measures, maintenance of hydration, and deflation of GI tract.

c. Congenital diseases. Mucoviscidosis, or cystic fibrosis of the pancreas, is a syndrome in which there is an abnormality of acinar secretions with disturbances being seen in the pancreas, liver, gallbladder, intestines and lungs. The emergency of the newborn period is the associated meconium ileus or obstruction of a patent intestinal lumen by inspissated meconium. Rarely are pulmonary lesions present at birth but, if so, the respiratory measures discussed previously should be placed into effect. The abdomen is frequently distended with dilated intestine, and occasionally symptoms of intestinal obstruction are present. Diagnosis is best established by family history (25 per cent expectancy in future children) and x-ray of the abdomen. Usually a flat plate is sufficient, showing a frothy appearance or evidence of a ruptured gut with meconium peritonitis (Fig. 6). Therapy is immediate surgical exploration and complete removal of the meconium ileus. A special pregnancy diet may be of some value prophylactically; a cystic diet for the infant should be started immediately upon diagnosis. Respiratory therapy should begin when pulmonary symptoms become apparent.

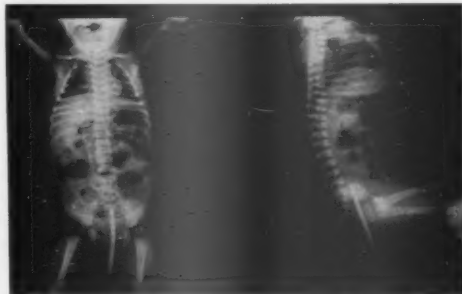


Fig. 6. Flat plate of abdomen showing typical frothy appearance seen in non-perforated meconium ileus of mucoviscidosis.

As previously mentioned, babies born of diabetic mothers may be more apt to develop pulmonary hyaline membrane disease, particularly if protective respiratory measures are not carried out during the immediate neonatal period. Children born with congenital syphilis may show a pneumonia alba (with an interstitial pneumonitis and thickening of the alveolar septa by mononuclear cell infiltrates). The best therapy here is to treat the syphilitic pregnant woman with massive doses of penicillin. Severely affected congenital syphilitics do not respond to therapy; in the milder cases 1.0 million units of penicillin daily over a ten-day period may be of considerable benefit.

2. Trauma and Intracranial Hemorrhage: Cerebral lesions responsible for death in the neonatal period are frequently associated with respiratory disturbances in the newborn. Even when seen alone, the symptoms may be so similar to those present with pulmonary pathology that diagnosis may not be established until postmortem examination.

a. Intraventricular hemorrhage. This is the most common cerebral lesion seen and accounts for approximately 10 per cent of all neonatal deaths, especially in the small, previsible, premature infants. Signs and symptoms may be present at the time of birth or may be delayed for hours or days after delivery. During this latent period, the infant may exhibit no abnormal signs or symptoms; occasionally he may appear unusually alert and hyperactive. Once symptoms appear, death usually follows within a relatively short period of time. Clinical manifestations are predominantly respiratory in nature with an irregular respiratory rhythm and pattern, periods of apnea, the appearance of cyanosis. Irritability and loss of the Moro reflex are usually present, and occasionally a bulging fontanelle may be noted. Petechiae may be present in many areas of the body. A spinal tap frequently reveals bloody or xanthochromic fluid. Treatment is aimed at relieving the pressure in the cerebrospinal system and preventing any further hemorrhage. The

baby should be handled as little as possible; the head should be elevated in these cases, otherwise the usual respiratory measures should be followed. Vitamin K may be of some value. The French have been studying the effect of giving large doses of alphatocopherol to mothers of expectant pretermatures, and vitamins P and C have been tried without much success in increasing their vascular resistance. An occasional life-saving intraventricular tap has been performed, but this is not recommended as a general procedure. If further bleeding can be prevented, spinal taps with the removal of small amounts of fluid may be of some benefit.

b. Intracranial trauma. Fortunately, this cause of infant mortality has been decreasing with the practice of better obstetrics. It is now usually seen after a difficult delivery (especially breech) but may follow an apparently simple, uncomplicated delivery. Postmortem examination reveals tears of the dural septa, usually the tentorium cerebelli, and associated subdural hemorrhage (death does not usually occur in the absence of this latter). Symptoms are usually apparent at or shortly after birth, or may be delayed for a period of two to three days. Respiratory manifestations are predominant, with apnea, increased irregularity in the respiratory pattern and cyanosis. Somnolence, twitchings or frank convulsions may occur. Shock and a bulging fontanelle may be present. X-ray studies and laboratory studies are of little value in diagnosis. Subdural tap through the coronal sutures may be negative, and should be repeated through the lambdoidal sutures, if clinical manifestations persist. Treatment is essentially similar to that for intraventricular hemorrhage—minimal handling, adequately humidified oxygen as indicated, slight elevation of the head, and the administration of vitamin K. Prophylactic antimicrobial therapy is wise, since fetal anoxia and concurrent pulmonary infection may accompany intracranial trauma. Subdural taps should be repeated if blood or fluid is encountered. Daily taps may be necessary to achieve gradual depression of the subdural spaces.

### Pathology Developing in the Neonatal Period

It is difficult to separate the conditions present at birth from those developing in the neonatal period. Many are progressive in nature, and it is these that we will discuss here.

1. **Pulmonary Hemorrhage:** This is of two types—inter- and intra-alveolar. In the former the hemorrhage may be in the subpleural, interstitial, or perivascular areas. The agonal "flame" hemorrhages or superficial ecchymotic areas are presumably caused by terminal anoxia; the perivascular and interstitial hemorrhages apparently due to anoxia are most frequently found in fetuses that die in utero. Subpleural petechiae may be seen frequently in infants following premature separation of the placenta. On the other hand, intra-alveolar hemorrhage is usually observed in infants a few hours to a few days old; this is usually in prematures under 2,000 gms, and is occasionally seen in erythroblastotic infants. The intra-alveolar blood may be aspirated maternal blood, or leakage from capillary injury sustained from intra-uterine anoxia. Clinically, the signs are those of respiratory distress; occasionally x-ray evidence of an accompanying atelectasis or pneumonia may be present. Therapy consists of a patent airway, suction, humidified oxygen and other resuscitative measures as indicated.

2. **Pneumonias:** There are many causes of pneumonias of the newborn: (1) aspiration of infectious amniotic fluid—staphylococcus, streptococcus or colon bacilli, (2) irritative pneumonia due to aspiration of sterile amniotic fluid, (3) atelectatic, congested and edematous lungs of asphyxiated infants are susceptible to infection, and fetal anoxia plays a leading role, (4) premature rupture of fetal membranes, long labors, complicated deliveries, caesarean sections, and (5) congenital syphilis and toxoplasmosis. Bronchopneumonia alone is not only a primary cause of death during the neonatal period, but is many times a contributory cause associated with such other conditions as fetal anoxia and pulmonary hyaline membrane. Bronchopneumonia may be present in the still born fetus, in the early hours of neonatal life, or

develop in the first few days of life, and is estimated to be present in about 10 per cent of neonatal deaths. Clinical diagnosis is often difficult. Temperature is of little help; the only apparent manifestations may be those of listlessness and refusal to nurse. Changes in breath sounds and rales may be difficult to make out, and may be confused with irregularities in pulmonary expansion. X-rays are of little value because of the diffuseness of pneumonic involvement. Diagnosis must be a presumptive one, based on a high index of suspicion in those infants who have a suggestive history, seem ill, are hyper-irritable, and may have associated problems discussed above. Occasionally a positive blood culture may be obtained. Delay of diagnosis and treatment until definite signs and symptoms are apparent may result in death. The resuscitative and post-resuscitative measures previously discussed should be employed, together with antimicrobial therapy—penicillin in conjunction with a broad spectrum antibiotic. We cannot overstress the importance of postural drainage in the head down position with elevation of the foot of the crib to 10 to 15 degrees. This is important, as the backward slope of the trachea and main bronchi make an angle of 20 to 30 degrees with the horizontal when the infant is placed in the prone position, and allows puddling of secretions, which the tiny infant is unable to eliminate properly. Resulting aspiration leads to secondary pneumonia if that is not already present. Minimal handling is again important, adequate but not over-hydration, oxygen for any dyspnea or cyanosis, cold mist with maintenance of a high humidity (Fig. 1d). Isolation is a must, and all newborn services should strive for sterilization of the air in delivery rooms and nurseries. Strict nursery technics should be followed.

3. **Obstructive Emphysema:** Congenital lobar emphysema, regional obstructive emphysema and pulmonary air cysts will be discussed here. Many etiologic factors have been postulated—congenital anomalies, including chondromalacia of the air passage structures (particularly the cartilaginous rings of the bronchi), check valvular bronchial obstruction, pulmonary necrosis

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1. Braceland, F.J.: *Texas State J. Med.* 51:287 (June) 1955.

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and trauma of birth or vigorous attempts at resuscitation without controlling the pressure or time of application of positive pressures. Clinically, these infants may have normal respirations at birth; in most cases, symptoms begin suddenly in the absence of infection. Dyspnea, cyanosis, and a wheezing type of respiration are usually the first symptoms to occur. Physical examination may be negative, or there may be lethargy, fever, asymmetry of the thoracic cage, retractions, shift of the mediastinal contents, absent breath sounds—or almost any pulmonary findings. Conservative therapy may not improve the infant's condition materially, and respiratory distress becomes progressively more apparent. When this occurs, a presumptive diagnosis of obstructive emphysema should be considered. Pneumo-mediastinum and pneumothorax, occurring independently or in combination, are demonstrated well by chest roentgenograms. Bronchoscopy may be helpful in ruling out regional or localized obstructive emphysema, which is the most frequent cause of either rupture of the visceral pleura or passage of air along perivascular spaces into the mediastinal tissues. Pulmonary cysts are usually readily visualized by x-ray. There is a variance of opinion as to therapy, depending upon the exact pathology present. In many instances, pathology cannot be adequately recognized without gross and microscopic examination. Since this is not feasible in many instances, therapy for each of the conditions individually is suggested.

a. Congenital lobar emphysema, according to Robertson and James and Shaw, is a

surgical emergency. This is true, particularly if chondromalacia of the air passages is present.

b. Regional or lobar obstructive emphysema may respond to conservative therapy. However, in many cases, surgical intervention may be necessary and this should be done if the course is not satisfactory. Caffey has treated pneumothorax, a variant of lobar obstructive emphysema, by repeated thoracic taps, with removal of air under water with some success.

c. Pulmonary air cysts may regress spontaneously under careful, prolonged observation (Caffey has adopted this conservative approach up to periods as long as forty months). On the other hand, a case of acute respiratory obstruction due to sudden and marked expansion of cysts should be considered a surgical emergency. Evaluation of the hazards of life under such circumstances should be arrived at jointly by the pediatrician and the surgeon.

4. Hyaline Membrane: This syndrome has been adequately discussed above under the conditions present at birth.

### Conclusion

All of these conditions are respiratory emergencies of the newborn and should be treated as such. Hesitation in their proper treatment may lead to death. The combined teamwork of family doctor, obstetrician, anesthesiologist, pediatrician, surgeon, bronchoscopist, roentgenologist, and pathologist promotes the ultimate best in therapy which can be offered to these 69-second-old infants who have their life expectancy of sixty-nine years to look forward to.

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### NEW AMA PAMPHLETS ON FAMILY DOCTOR

Expert advice concerning the importance of periodic health examinations is capsuled in an attractive new pamphlet recently published by AMA's Council on Rural Health. Titled, "Check and Know," this 16-page booklet points up the advantages of having a complete physical checkup at regular intervals and keeping an accurate health record of all members of the family. Another pamphlet, designed as a companion piece,

discusses the reasons for having a family doctor and for having a sound doctor-patient relationship. The second pamphlet, also 16 pages, is entitled, "A Member of the Family—Your Doctor."

Samples of each are being sent to directors of extension services and home demonstration leaders of land grant colleges, leaders of farm bureaus and the Grange, and members of state rural health committees. State medical societies may secure additional copies from the Council.

# Management of Diabetes During Pregnancy\*

E. Paul Sheridan, M.D., and  
Richard C. Cullen, M.D.

DENVER

*Proper medical management of the diabetic mother, throughout the gravid state, is the most important factor in reducing fetal mortality. In the past, it has been appallingly high. Fetal salvage at last can keep pace with maternal survival in properly managed diabetics.*

THE importance of proper management of diabetes during pregnancy cannot be overestimated. Only by careful, intelligent supervision of diabetes throughout the gravid state can we hope to maintain maternal health and reduce the fetal mortality rates which have been appallingly high. Prior to the discovery of insulin, diabetics seldom became pregnant. This was due to two things: (1) few who developed diabetes in childhood survived to a marriageable age, and (2) those who developed the disease after adolescence were so poorly controlled that they were not fertile. Thus it has only been in the past twenty to twenty-five years that the treatment of pregnant diabetics has become a medical problem of any magnitude.

During the early years of insulin usage both maternal and fetal mortality rates were high. However, with gradual improvement in the management of diabetics over the years, the maternal mortality rate has dropped and now approximates that in non-diabetic women. The fetal salvage, however, has failed to keep pace. A review of world literature up to 1944 discloses reports of 924 deliveries in diabetic women with a 37.6 per cent fetal mortality.

There are several factors which contribute to fetal mortality in diabetics. Poor control of the diabetic state during pregnancy is the most important reason for high fetal mortality. It has been repeatedly shown that fetal

mortality rates are markedly higher in poorly controlled diabetics than in those that are well controlled throughout pregnancy. Other factors contributing to fetal mortality are: (1) increased incidence of toxemias and hydramnios, (2) infants are often premature, (3) large size of babies leads to obstetrical difficulties, and (4) babies frequently have congenital abnormalities incompatible with life.

The proper management of the pregnant diabetic requires close cooperation between the clinician and the obstetrician. However, the responsibility of carrying these patients safely through pregnancy without additional hazards or complications lies chiefly with the clinician. We believe that a detailed history and thorough physical examination with special attention to the cardio-vascular system including the retinal, peripheral, and coronary vessels is very important. Part of our study includes the following laboratory procedures: Complete blood count, blood chemistry, urinalysis, x-ray of the chest, x-rays of pelvis for evidence of calcified vessels, and others as indicated. After the initial work-up, a complete evaluation of the patient is made to determine the wisdom of permitting her to continue through her pregnancy. Therapeutic abortions should be infrequent. Obviously patients with serious conditions such as extensive vascular or kidney disease where therapeutic abortion is indicated, should be aborted at an early date.

We believe that the pregnant diabetic should be seen by the clinician approximate-

\*Presented at the Regional Meeting, American College of Physicians, Colorado Springs, Colorado, January 15, 1955.

ly every two weeks during the first and second trimesters and at weekly intervals thereafter. At each visit we get a blood sugar determination and complete urinalysis. Careful attention is paid to weight changes, blood pressure, evidence of edema, urinary findings and changes in retinal vessels.

Rigid control of the diabetes is essential, maintaining a proper balance between diet and insulin and exercise. The diet should be carefully calculated to insure control of the diabetes, control of the weight gain and adequate intake of necessary vitamins and minerals. The total caloric requirements necessary for a normal pregnancy are usually around 30 to 35 calories per kilogram. In our experience, 150 to 200 grams of carbohydrates are usually adequate. This may be varied during the course of pregnancy according to weight gain and the renal threshold, which will be discussed later. Protein is increased in the diabetic diet with a recommended  $1\frac{1}{2}$  to 2 grams per kilogram. Fats are kept low. Salt is usually restricted in cooking and none added at the table. We believe that strict adherence to the prescribed diet is necessary for good diabetic control, especially during pregnancy.

Every pregnant woman with true diabetes regardless of the duration, severity or ease of control, should probably receive insulin throughout her confinement. We feel that patients who are considered mild diabetics and who have not taken insulin previously, should probably receive small doses throughout their course of pregnancy. It is felt that this may help to avoid certain complications. Intermediate acting insulins such as N.P.H. and Lente Insulin seem best suited for most diabetics during pregnancy. Many of these patients get along nicely on one dose of insulin in the morning. Because of frequent wide fluctuations of blood sugar and the progressive difficulty in controlling some women in pregnancy, it sometimes becomes necessary to use a mixture of the intermediate insulin and crystalline insulin in the morning. It is occasionally necessary to augment this with doses of crystalline insulin at intervals during the day. Insulin requirements usually increase progressively to term and this increase is most marked during the last trimester.

One must be constantly aware of the lowered renal threshold which is common during pregnancy, thus creating difficulties in diabetic control. It makes glycosuria a misleading indicator as to the state of control. If attempts are made to make the urine sugar free by increasing insulin, hypoglycemic attacks will result. Conversely the loss of sugar in the urine and the concomitant decrease in the amount of carbohydrate metabolized in the body may lead to ketosis. This can be remedied by increasing the amount of carbohydrate intake in the diet. Renal thresholds are readily determined by blood sugar and urine sugar determinations taken at each office visit at different times of the day over a period of time.

The major controversial issue in the management of the pregnant diabetic at the present time is over the use of hormonal therapy. In 1934 Smith and Smith<sup>1</sup> found that, in toxemias of pregnancy, there was a fall in serum levels of estrogen, a decrease in the excretion of progesterone and a rise in the level of the serum chorionic gonadotropin. Nelson, Gillespie and White<sup>2</sup> later found that a large number of pregnant diabetics had some imbalance of sex steroids as indicated by an abnormal rise in chorionic gonadotropin and a low value in urinary estrogen and progesterone as measured by its product pregnanediol. We know that Dr. Priscilla White has prescribed hormones enthusiastically in the form of Stilbesterol and Progesterone in increasing amounts during pregnancy and firmly believes that it has reduced the incidence of spontaneous abortions, toxemias, and premature labors. Her latest fetal mortality rate of 10 per cent is indeed impressive. It is even more impressive when one remembers that she is dealing chiefly with young, severe diabetics.

Others, however, are not as enthusiastic about the use of hormones. Reis, DeCosta, and Allweiss<sup>3</sup> had a fetal mortality rate of 13.6 per cent; Miller, et al.,<sup>4</sup> 14.7 per cent; Hall and Tillman<sup>5</sup> 18.3 per cent. Several others have reported rates below 20 per cent without the use of hormones. It is the impression of some of these writers that hormones have no definite value in the management of the pregnant diabetic. In view of

the conflicting opinions on this subject we believe that further long term evaluation is necessary before definite conclusions can be drawn.

Another problem in the management of the pregnant diabetic about which there is a variance of opinion, is the proper mode of delivery and whether to terminate these pregnancies prematurely. It is becoming more widely accepted that premature termination of the pregnancy is desirable. The present high cesarean rate in most authors' series would substantiate this view. Early termination seems indicated because toxemias and enterurian deaths are frequent in the last four weeks. There also seems to be a greater tendency for progression of vascular complications during this phase. And, of course, it is well known that full term babies of diabetic mothers are usually large in size, giving rise to obstetrical difficulties. Premature termination is an attempt to produce a living fetus before these abnormalities develop. We believe that premature termination in selected cases has been an important factor in lowering the fetal mortality rate and decreasing the morbidity in mothers.

Every patient is an individual problem and every patient should be re-evaluated at the thirty-sixth week to determine the advisability of terminating the pregnancy. We feel that all patients who have had diabetes over ten years or who have vascular complications of any degree or patients with obvious obstetrical reasons for termination should be delivered prematurely. Mild diabetics who have had diabetes for a short period of time and who are otherwise in good health, should probably be carried to term providing the size of the infant is not too large. We prefer cesarean delivery over artificial labor induction in premature termination. It has been our experience that the patient's diabetes is more easily controlled with abdominal removal than when labor is induced. In the latter the onset is indefinite and the labor sometimes prolonged. The decision for early termination rests with both the clinician and the obstetrician and this decision is sometimes a difficult one.

Meticulous care of the diabetic is paramount during delivery and for several days

postpartum regardless of the mode of delivery. One should be extremely cautious in giving insulin to these patients during the first twenty-four to forty-eight hours postpartum as severe hypoglycemia frequently occurs. Deaths have been reported. Many patients may go as long as seventy-two hours following delivery without requiring insulin. If patients with a tendency to postpartum hypoglycemia are given even small amounts of insulin they may easily be thrown into a severe hypoglycemic state of shock which is often extremely difficult to correct. Because of postpartum hypoglycemia, frequent blood sugar determinations during the first twenty-four to forty-eight hours are imperative.

We have briefly outlined below our general plan of management of these patients going through cesarean delivery. Essentially the same routine is followed as closely as possible with patients going to full term and delivering normally.

1. Attempt to have early morning surgery.
2. Spinal anesthesia preferred.
3. Omission of insulin for twenty-four hour period prior to surgery and no insulin morning of surgery.
4. Intravenous glucose solution (5 per cent In  $H_2O$ ) started one-half hour before surgery and continue throughout time of surgery.
5. Blood sugars every six hours for first twenty-four hours.
6. Subsequent glucose intravenously during remaining twenty-four hours to insure at least 100 grams carbohydrate intake during that period.
7. Use of regular insulin for first twenty-four to forty-eight hours to control hypoglycemia.
8. Gradual reinstitution of diet as tolerated.
9. Intermediate acting insulin started second or third day.

We would like to present a preliminary report of fifty pregnant diabetics which we have treated over a seven-year period from 1947 to 1954. In evaluating fetal mortality statistics in the literature one must be certain as to whether the author's figures refer to total fetal mortality or to fetal mortality

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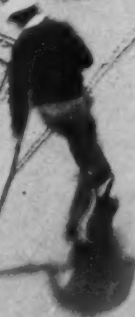


TABLE I

| Group     | Duration Diabetes Years | No. Pts. | Fetal Deaths | Maternal Deaths | Cesarean | Vaginal Delivery | Fetal Deaths % |
|-----------|-------------------------|----------|--------------|-----------------|----------|------------------|----------------|
| I         | new                     | 2        | 0            | 0               | 0        | 2                | 0              |
| II        | 0-9                     | 11       | 1            | 0               | 5        | 6                | 9              |
| III       | 10-19                   | 17       | 2            | 0               | 14       | 3                | 11             |
| IV        | 20+                     | 6        | 1            | 1               | 4        | 2                | 16             |
| Total No. |                         | 36       | 4            | 1               | 23       | 13               |                |
| Per cent  |                         | 100%     | 11%          | 3%              | 64%      | 36%              | 11%            |

(Average Duration Diabetes—11.8 years)

after viability of the fetus. Most authors consider only viable pregnancies. This has been our policy, using the twenty-eighth week as the beginning of the viable stage.

Of the fifty pregnancies in our series, ten or 20 per cent had spontaneous abortions; and four or 8 per cent received therapeutic abortions. This represents a total fetal loss of 28 per cent before viability. The remaining thirty-six, or 72 per cent of the total, became viable pregnancies.

The thirty-six viable pregnancies were classified in four groups according to the duration of the diabetes at the time of pregnancy, as follows:

Group I—Those patients who developed diabetes during their pregnancy.

Group II—Those who had diabetes from zero to nine years.

Group III—Those who had diabetes for ten to nineteen years.

Group IV—Those having had diabetes for twenty years or longer.

All patients were managed in general throughout their course of pregnancy as we have outlined above. All thirty-six patients received hormonal therapy of one kind or another in varying amounts. Thirty patients, or 83.3 per cent, received hormones throughout their entire pregnancies starting at approximately the eighth to nineteenth week. The remaining six were seen late in pregnancy and received minimal amounts of hormones. Ten patients received both Stilbestrol and Progesterone whereas twenty patients received Stilbestrol alone. For the past three-year period we have used only Stilbestrol and have discontinued the use of Progesterone.

From Table I it is evident that the largest number of patients, seventeen, occur in the 10 to 19 year group. Moreover, twenty-three, or approximately 65 per cent, were diabetics of over ten years' duration. There were four fetal deaths, consisting of two stillbirths and two neonatal deaths, all occurring in groups II, III, and IV, giving a total fetal mortality rate of approximately 11 per cent.

TABLE II

|                  | No. Cases | Per Cent | Number Fetal Deaths | Per Cent Fetal Mortality |
|------------------|-----------|----------|---------------------|--------------------------|
| Vaginal Delivery | 13        | 36       | 1                   | 7.6                      |
| Cesarean         | 23        | 64       | 3                   | 13.0                     |
| Total            | 36        | 100      | 4                   | 11.0                     |

It will also be noted in Table II that twenty-three patients, or 64 per cent, were delivered prematurely by cesarean section between the thirty-sixth and fortieth week. There was one maternal death due to postpartum uterine hemorrhage. No maternal morbidity occurred in any of the other patients except for a near fatal episode of severe prolonged hypoglycemia after cesarean section in one patient.

TABLE III

| Relation of Fetal Loss to Diabetic Control |           |                 |
|--|-----------|-----------------|
| Type of Control                            | No. Cases | Fetal Mortality |
| Good                                       | 21        | 5%              |
| Fair                                       | 11        | 20%             |
| Poor                                       | 4         |                 |

Three of the fetal deaths, Table III, occurred in those delivered by cesarean section, a 13 per cent loss. There was one death in the vaginal group, a 7.6 per cent loss. Both neonatal deaths occurred with cesarean deliveries.

Diabetic control was considered good in twenty-one of the thirty-six cases. The remaining fifteen were considered fair to poor because of poor cooperation, marked fluctuation of blood sugars, episodes of acidosis, and/or hypoglycemia. You will note that the fetal mortality in the poorly controlled patients is 20 per cent, which is four times the 5 per cent mortality in the well controlled group.

### Conclusion

We have attempted to outline in general the medical management of diabetics during pregnancy, realizing that many questions still remain unanswered. We are convinced that the most important factor in reducing fetal mortality is good diabetic control regardless of whether hormones are

used or whether pregnancies are terminated. We have presented a preliminary report of thirty-six viable diabetic pregnancies of our own with what we believe to be a satisfactory fetal salvage rate of 89 per cent. This series is small, but it does represent a nucleus for continued study in an effort to determine every possible means which may help us lower the fetal mortality in diabetic pregnancies still further.

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## Malpractice Claims In Colorado

Report by the Medicolegal Committee  
of the Colorado State Medical Society.

IN 1955 the Medicolegal Committee of the Colorado State Medical Society undertook a statistical study of professional liability claims—or so-called malpractice claims—made against Colorado physicians during the five-year period from January 1, 1950, to December 31, 1954. Most of these claims have now reached a conclusion, either by court action or by negotiation. A few cases have not yet been closed; but the pattern of the study is clear, and the findings can be presented.

During the five-year period under consideration there were 90 claims against physicians for alleged acts of negligence. This gives an average of 18 claims a year, or a ratio of one claim annually to 77 physicians.

There is surprising uniformity in the number of claims per annum, the figures for the five-year period being as follows:

|           |           |
|-----------|-----------|
| 1950..... | 18 claims |
| 1951..... | 16 claims |
| 1952..... | 16 claims |
| 1953..... | 19 claims |
| 1954..... | 21 claims |

As a matter of information it can be added

that there were only 13 claims during 1955. These cases are not included in our present five-year investigation.

A word of explanation regarding "claims" is in order. A claim, in the present study, is any demand for money or any threat of suit alleging negligence. A claim may, or may not, result in a lawsuit. Sometimes a claim is made for a small sum of money representing the patient's additional hospital expense because of prolongation of his illness. In another case there may be a claim for alleged damages plus "exemplary damages," and the monetary demand may be large. It is the belief of the committee that the number of reported claims in this study is relatively high because of the Society's insistence that it be advised of all claims immediately—even though a claim may seem preposterous or insignificant.

There is a confusing factor in the present statistical study because a claim may be made against several physicians in connection with a single alleged act of negligence. Thus the surgeon, the anesthetist, and the roentgenologist may all be sued when a fracture patient encounters unexpected

complications. In one instance six physicians in a group were sued as a result of a single alleged "tort." If these multiple claims are counted in the statistical study, the 90 cases in the five-year period would be increased to 117. The average number of claims per annum would also be increased, from 18 to 23.4. The ratio of claims to physicians would be 1 to 59 instead of 1 to 77.

Another explanation should be made regarding the incidence of claims. This report considered the claims actually made during the years 1950-1954, though some of the alleged malpractice may have occurred several years earlier. In other words, there is often a lapse of time between the alleged dereliction of the State law, a patient has two years tort and the claim that results from it. Unin which to file a suit after discovering a supposed tort, and a minor has two years after reaching legal age. Thus the medical incident and the legal claim may be separated by several years. It is not possible to rectify this discrepancy in a five-year report, but it can reasonably be supposed that past and future claims balance one another in terms of monetary demands, and that the statistics of the report are reasonably reliable.

Among the 90 cases of the past five years, 82 have now been closed. Among the remaining eight cases, four or five have apparently been dropped. Two cases have been set for hearing. One case, with a judgment against a physician, is awaiting appeal to the Supreme Court. For statistical purposes, the award to the claimant in this case is included in the figures that follow.

The total payments made to claimants during the past five years amount to \$146,974.46. Of this amount, physicians have contributed \$4,540.00, thus the insurance carriers have paid claims to the amount of \$142,434.46. These combined payments are distributed over the five years as follows:

|            |             |
|------------|-------------|
| 1950 ..... | \$29,775.00 |
| 1951 ..... | 14,200.00   |
| 1952 ..... | 52,500.00   |
| 1953 ..... | 13,113.01   |
| 1954 ..... | 37,386.45   |

The cost of defending lawsuits and negotiating settlements is a large item in the

insurance expense. These figures, as supplied by the companies themselves, amount to \$60,906.47 for the five-year period. The breakdown by years is as follows:

|            |             |
|------------|-------------|
| 1950 ..... | \$19,289.34 |
| 1951 ..... | 7,417.72    |
| 1952 ..... | 15,558.00   |
| 1953 ..... | 13,377.74   |
| 1954 ..... | 5,263.67    |

From the foregoing figures it will be seen that the total cost of meeting professional liability claims over the five-year period was \$207,880.93. This amounts to an annual sum of \$29.93 per member of the Society, based on an average membership of 1,389 during the five-year period. Though there are eight cases not yet officially closed, it seems that the final apportionment of cost per member will be approximately \$30.00, and for all practical purposes this figure can be considered as final.

It should be noted that the legal costs in the amount of \$60,906.47 represent attorneys' fees, cost of investigation, and other items of expense. If the cost of the insurance companies' office maintenance were added, this figure would be affected, though not to a large extent with only 18 cases per annum.

In summary it can be said that the number of professional liability claims against Colorado physicians is consistently low, and it is notably low when compared with New York City, for instance, where the incidence of claims is more than 100 per cent higher. It is interesting to note that 40 per cent of claims in Colorado are made against surgeons, and 20 per cent against orthopedists. Thus these two specialties encounter 60 per cent of liability claims lodged against the medical profession.

#### **The Medicolegal Committee, 1954-1955**

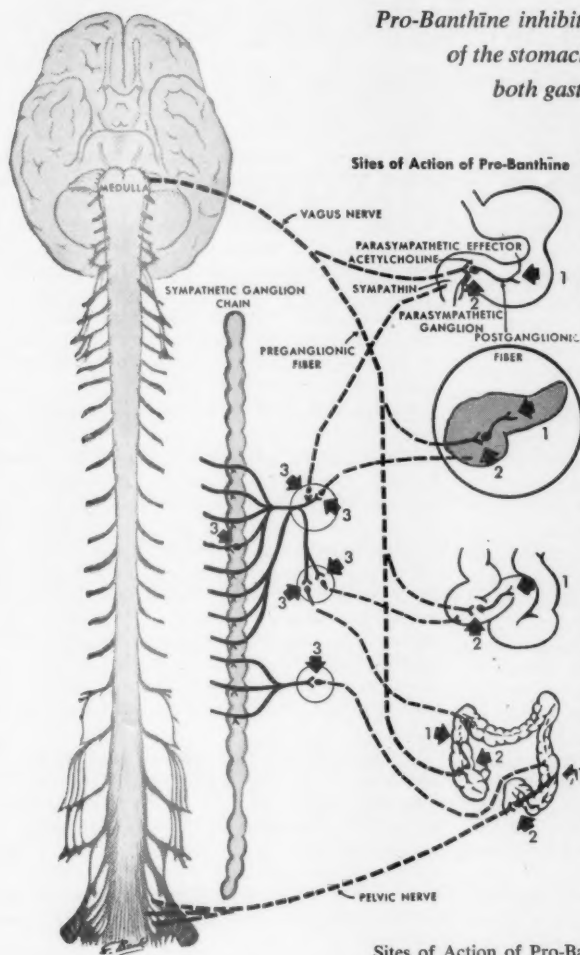
Hamilton I. Barnard, M.D.  
William W. Haggart, M.D. (Deceased).  
Horace G. Harvey, M.D.  
Ervin A. Hinds, M.D.  
Edward J. Meister, M.D.  
Ralph H. Verploeg, M.D.  
C. S. Bluemel, M.D., Chairman

#### **The Medicolegal Committee, 1955-1956**

C. S. Bluemel, M.D.  
John D. Gillaspie, M.D.  
Horace G. Harvey, M.D.  
Ervin A. Hinds, M.D.  
Edward J. Meister, M.D.  
Hamilton I. Barnard, M.D., Chairman.

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1. Jones, C. A.: Arch. Int. Med. 96:332 (Sept.) 1955.
2. Zollinger, R. M.: Postgrad. Med. 15: 323 (April) 1954.
3. Woodward, E. R.: M. Clin. North America 38:115 (Jan.) 1954.
4. Schwartz, I. R., and Hinton, J. W.: Personal communication, February, 1955.

**Sites of Action of Pro-Banthine.** The principal site of action of Pro-Banthine is on the parasympathetic system where it exerts a dual action while exerting a single and lesser action on the sympathetic system: (1) parasympathetic effector; (2) parasympathetic ganglion; (3) sympathetic ganglion (see arrows).

**SEARLE**

# ORGANIZATION

## Colorado



### *Report on Chicago AMA Session by Colorado Delegates*

The 105th Annual Session of the American Medical Association was held in Chicago from June 11 to 15, and Colorado was very well represented. A total of 27,115 persons attended the session, including 9,969 physicians, and of these doctors, seventy-eight registered from Colorado.

Drs. Robert T. Porter, George R. Buck and Kenneth C. Sawyer went to Chicago two days early to meet with members of the University of Colorado Board of Regents at the University of Chicago and study the Chicago system of medical school management. The Chicago faculty was most courteous to the Colorado delegation, and I am certain that all present learned a great deal from these men. Whether or not the Chicago plan will be applicable to our own University is dubious. This will come out in a report to the State Society at an appropriate time.

Colorado was also well represented in the scientific programs of both the American Medical Association and the many specialty groups meeting in Chicago about the same time. Drs. Gilbert Blount and Cuthbert Owens participated in the meeting of the Society for Vascular Surgery, preceding the AMA meeting, and Dr. Frank B. McGlone was elected to full membership in the American Gastroenterological Society, indeed a singular honor. Colorado members participating in the Scientific Meeting included Drs. Blount, Gerald Frumess, Henry Swan, Leighton Anderson, Ivan W. Philpott and Robert Woodruff. Dr. Philpott received honorable mention for his exhibit on "Early Nasal Injuries, a Factor in Facial and Dental Deformity."

The Colorado Hospitality Suite was in The Palmer House, which was also AMA House of Delegates headquarters. Our hospitality suite was open daily, and gave everyone an opportunity to see their friends from Colorado and meet people who had previously resided in the State, as well as gather with other friends from various parts of the country. President Porter, President-Elect Buck and Executive Secretary Sethman were in charge of our suite, and were aided by the other

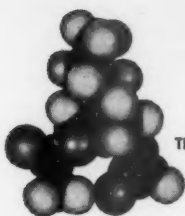
officers who completed the "official" Colorado delegation. These included Colorado's two AMA Delegates, Drs. E. H. Munro and K. C. Sawyer; their Alternate-Delegates, Drs. H. E. McClure and I. E. Hendryson; Dr. J. M. Perkins, Constitutional Secretary; Dr. Samuel P. Newman, Past President and member of the AMA Council on Scientific Assembly; Dr. Fred H. Humphrey, Past President and member of the AMA Council on Rural Health, and Dr. George A. Unfug, Past President and member of two AMA Committees, on Joint Accreditation Commission and on Guides to Grievance Committees.

In addition to the many regular functions of an AMA Annual Session, Colorado was represented at several ancillary meetings. Dr. Hendryson covered the annual meeting of the Council on National Defense, at which disaster preparedness, professional contributions for disaster planning and many other problems pertaining to civil defense were discussed by a distinguished panel. Dr. W. W. Wasson of Denver served this year as a member of the AMA Committee on Awards, which judges all the scientific exhibits. Mr. Sethman represented us at the annual meeting of stockholders and directors of the State Medical Journal Advertising Bureau. Most of the delegation attended the annual meeting of the Conference of Presidents and Other Officers of State Medical Associations, where we gained a great deal of practical information.

A detailed report of the business phase of the AMA Session follows in a carefully condensed report prepared by AMA Secretary Dr. George F. Lull. Controversial subjects acted upon were the ones concerned with the report of the Council on Medical Service, pertaining to private practice by medical school faculty members, and the report of the special committee to review the functions and operations of the Joint Commission on Accreditation of Hospitals. The conclusions of this committee's report were adopted, and are presented in full in Dr. Lull's report, below. They are important to all our Western States and especially in Colorado, and should be studied in detail.

Contributions to the American Medical Education Foundation were discussed in some detail. Illinois presented a check for \$165,000.00, which was certainly commendable. It is their policy to assess each member \$20.00 a year for the AMEF. I hope that this amount per member will have been exceeded by Colorado's voluntary contributions when our report for the year is finally presented.

Our delegates presented two resolutions, one calling upon the government to return the distribution of Salk anti-polio vaccine to normal commercial channels now that the emergency pertaining to beginning manufacture has passed, and the other asking AMA Councils to revise their booklet of Guides to Management and



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Union Health Centers so that it will agree with the Principles of Medical Ethics. Both of Colorado's resolutions were passed by the AMA House of Delegates without dissenting votes.

By the time this report can be published in our Rocky Mountain Medical Journal, the Journal AMA will have carried even more details concerning some of the business actions, and all our members are advised to refer back to those issues frequently to see what policies were adopted or rejected, and how those policies were arrived at in the great national organization to which we all subscribe.

For the Colorado Delegation:

KENNETH C. SAWYER, M.D.,  
Senior Colorado Delegate.

#### **Report on Actions of the House of Delegates American Medical Association**

Hospital accreditation, evaluation of graduates of foreign medical schools, private practice by medical school faculty members, federal aid to medical education and premature publicity on new drugs were among the major subjects acted upon by the House of Delegates at the American Medical Association's 105th Annual Meeting held June 11-15 in Chicago.

Dr. David B. Allman, surgeon of Atlantic City, N. J., was named unanimously as President-Elect for the coming year. A member of the AMA Board of Trustees since 1951 and also chairman of the Committee on Legislation, Dr. Allman will become President of the American Medical Association at the June, 1957, meeting in New York City. He will succeed Dr. Dwight H. Murray of Napa, California, who took office at the Tuesday evening inaugural program in the Chicago Civic Opera House.

The House of Delegates selected Dr. Walter L. Bierring of Des Moines, Iowa, as recipient of the 1956 Distinguished Service Award of the American Medical Association for his long and outstanding contributions to medicine and humanity. Dr. Bierring, a Past President of the AMA, was honored for his achievements in the fields of public health and medical examining board work. He formally accepted the award at the Tuesday inaugural program.

Total registration at the end of the fourth day of the meeting, with half a day still to go, had reached 22,394, including 9,793 practicing physicians and 12,601 residents, interns, medical students and guests.

#### **Hospital Accreditation**

The House of Delegates approved the report of the Committee to Review the Functions of the Joint Commission on Accreditation of Hospitals, which was appointed by the Speaker as a result of action taken at the June, 1955, meeting. The Committee came to the following conclusions:

"1. Accreditation of hospitals should be continued.

"2. The Joint Commission should maintain its present organizational representation.

"3. The Board of Trustees should report annually to the House of Delegates on the activities of the Joint Commission.

"4. Physicians should be on the administrative bodies of hospitals.

"5. General practice sections in hospitals should be encouraged.

"6. Staff meetings required by the Joint Commission are acceptable, but attendance requirements should be set up locally and not by the Commission.

"7. The Joint Commission should not concern itself with the number of hospital staffs to which a physician may belong.

"8. The Joint Commission is not and should not be punitive.

"9. The Joint Commission should publicize the method of appeal to hospitals that fail to receive accreditation.

"10. Reports on surveys should be sent to both administrator and chief of staff of hospital.

"11. Surveyors should be directly employed and supervised by the Joint Commission.

"12. Surveyors should work with both administrator and staff.

"13. New surveyors should receive better indoctrination.

"14. Blue Cross and other associations should be requested not to suspend full benefits to non-accredited hospitals until those so requesting have been inspected.

"15. The American Medical Association should conduct an educational campaign for doctors relative to the functions and operations of the Joint Commission.

"16. The Committee also suggests that the American Medical Association and the American Hospital Association encourage educational meetings for hospital boards of trustees and administrators either on state or national levels to acquaint these bodies with the functions of accreditation.

"17. This Committee asks to be discharged upon submission of this report to the House of Delegates."

The House also approved a reference committee suggestion that the following statement be added to strengthen the report:

"The Committee recommends that the commissioners to the Joint Commission on Accreditation of Hospitals, appointed by the Board of Trustees of the American Medical Association, urge that Commission to study:

"1. The problems of the exclusion from hospitals and arbitrary limitation of the hospital privileges of the general practitioner, and

"2. Methods whereby the following stated principles may be achieved:



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#### **Graduates of Foreign Medical Schools**

The House of Delegates approved in principle a program for the evaluation of graduates of foreign medical schools seeking hospital positions in the United States. The proposed program was developed by the Cooperating Committee on Graduates of Foreign Medical Schools, representing the AMA Council on Medical Education and Hospitals, American Hospital Association, Association of American Medical Colleges and Federation of State Medical Boards of the United States.

The following principles were emphasized by the Council on Medical Education and Hospitals in its report recommending AMA participation in the program:

"1. Although the responsibility to share educational opportunities in medicine is recognized, the primary concern must be for the health care of the American public. Thus, before assuming responsibility for the care of patients as interns or residents, all graduates of foreign medical schools (immigrants, exchange students and American graduates of foreign medical schools) should give evidence, as nearly as can be measured, of having reached a level of educational attainment comparable to that of students in American schools at the time of graduation.

"2. The primary objective of this Committee is to devise an effective mechanism for measuring educational attainment in the absence of intimate and continuing knowledge of the educational background of foreign-trained physicians. This mechanism should provide hospitals with pertinent information regarding the medical qualifications of foreign-trained physicians seeking positions as interns or residents. It should not interfere with the hospital's privilege of making its own selection among qualified physicians, nor should it serve as a substitute for or interfere with the normal licensure procedures of the various state boards.

"3. It is not intended that this mechanism be applicable to those foreign medical school graduates in this country as temporary students participating in programs of medical and related studies in recognized universities, medical schools and postgraduate schools, who by the very nature of their study are not involved in the responsibility of patient care."

The proposed plan calls for establishment of a central administrative organization to evaluate the medical credentials of foreign trained physicians desiring to serve as interns or residents in American hospitals. Basic requirements would in-

clude satisfactory evidence of at least eighteen years of total formal education, including a minimum of thirty-two months in medicine exclusive of any time which in this country would be considered as pre-medical study or internship. Applicants with satisfactory credentials then would take a screening examination to determine their medical knowledge and their facility with the English language. Successful applicants then would be certified to hospitals and other interested organizations, with the approval of the foreign-trained physicians concerned.

#### **Private Practice by Medical School Faculty Members**

Another major action by the House involved the problem of private practice by medical school faculty members, which has been under study by the Committee on Medical and Related Facilities of the Council on Medical Service. The House adopted a Council report which stated "that it shall be the policy of the American Medical Association that funds received from the private practice of medicine by salaried members of the clinical faculty of the medical school or hospital should not accrue to the general budget of the institution and that the initial disposition of fees for medical service from paying patients should be under the direct control of the doctor or doctors rendering the service."

It was further recommended that adequate liaison be developed and maintained between each county medical society and any medical school or schools in its area; that the Council on Medical Education and Hospitals and the Association of American Medical Colleges urge all medical schools to assist and work with medical societies in developing such liaison, and that publicity emanating from a medical school should be in good taste and of a type which has the approval of the general medical community in that area.

The adopted report also said: "It is not in the public or professional interest for a third party to derive a profit from payment received for medical services, nor is it in the public or professional interest for a third party to intervene in the physician-patient relationship."

#### **Federal Aid to Medical Schools**

One of the most controversial subjects of debate on the floor of the House was a resolution expressing strong opposition to S. 1323, a bill in Congress providing for one-time, matching grants to medical schools for construction purposes. The Association in recent years has been supporting such legislation in principle, with certain reservations concerning details of some provisions. The House reaffirmed that policy by approving a reference committee statement which said:

"We appreciate the intent with which this resolution was introduced, but at the same time we feel that there are many economic and geo-

graphical factors involved, which might not make this resolution practical on a national level. Inasmuch as no evidence was offered to this Committee to justify a change in the previously declared policy of the House of Delegates, your Committee recommends that this resolution be not adopted."

#### **Premature Drug Publicity**

The House adopted a substitute resolution which read:

"Whereas, In recent years, events have indicated the necessity for a closer liaison between the pharmaceutical manufacturer and the American Medical Association; and

"Whereas, In view of the tremendous number of new drugs being developed and the expanding research programs in medical colleges, clinics and hospitals being financed by the drug industry, it is imperative that the manufacturer and the medical profession develop cooperatively guiding principles which will protect the American people from being subjected to the premature release of information pertaining to new products or technics; and

"Whereas, Competition within the pharmaceutical industry has become extremely keen so that in the advertising of their products drug manufacturing firms have been forced into the expenditure of larger and larger sums of money and in increasingly broader fields of advertising; therefore be it

"Resolved, That the Board of Trustees of the American Medical Association appoint a liaison committee to meet with representatives of the pharmaceutical manufacturers to accomplish this objective."

#### **Miscellaneous Actions**

Among many other actions on a wide variety of subjects, the House also:

Approved a Board of Trustees statement on Social Security which included the following: "It is imperative that we distinguish clearly between this problem of coverage of physicians and the far more dangerous disability proposal. The fact should be recognized that the shape of medical practice in the future is not directly related to the inclusion or exclusion of physicians under OASI. It is a matter of vital importance to us as individuals, but it cannot, per se, stimulate further government intrusion into medical care. On the other hand, the disability amendment obviously brings the Social Security Administration closer to the regulation of medical care than ever before."

Adopted a resolution amending the By-Laws to provide that the Vice President, Treasurer, Speaker and Vice Speaker of the House of Delegates shall be ex-officio members of the Board of Trustees with all the rights and duties of the Board without the right to vote.

Increased membership of the Council on Medical Service from six to nine active or service members and eliminated all ex-officio members except the immediate Past President.

Directed the Council on Medical Service and the Council on Industrial Health to reconsider the "Guiding Principles for Evaluating Management and Union Health Centers" through their joint Committee on Medical Care for Industrial Workers and to so revise the guides that they conform completely with the Principles of Medical Ethics.

Authorized the Committee on Federal Medical Services to make a continuing study of all aspects of VA medical activities under the basic policy established in June, 1953, and suggested reconsideration of the temporary exceptions made at that time with respect to neuropsychiatric and tuberculous disorders.

Recommended that the Board of Trustees select New York City as the place of the 1961 annual meeting.

#### **Opening Session**

At the Monday opening session Dr. Elmer Hess, outgoing AMA President, warned that the medical profession must be prepared to face an all-out drive by some labor groups for national compulsory health insurance. Dr. Dwight H. Murray, then President-Elect, told the House that general practitioners and specialists must guard against "any cleavage within our profession," and he urged strength through unity.

Dr. Lowell T. Coggeshall, special assistant to Secretary Marion B. Folsom of the U. S. Department of Health, Education and Welfare, assured the House that the over-all medical objectives of HEW are in accord with those of the AMA. A memorial plaque honoring the late Dr. Carl M. Peterson, Secretary for seventeen years of the AMA Council on Industrial Health, was presented by Dr. Ross McIntire on behalf of the President's Committee on Employment of the Physically Handicapped. The Illinois State Medical Society presented a check for \$164,940 to the American Medical Education Foundation.

#### **Inaugural Program**

Dr. Murray, in his inaugural address at the Tuesday evening ceremony in the Chicago Civic Opera House, declared that "what we need most in medicine today is to find some way of combining modern scientific methods with the personal, friendly touch of the old-time family doctor." The inaugural program, which included the Blue-jacket Choir of the U. S. Naval Training Center at Great Lakes, Illinois, was telecast over Station WBKB in Chicago.

#### **Election of Officers**

In addition to Dr. Allman, the new President-Elect, the following officers were elected:

Dr. F. S. Crockett of Lafayette, Indiana, Vice-

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Keep his diet out of the conversation. Sympathy from friends leads only to sympathy for himself. And self-pity is death to a diet.

The patient with a diet outline that permits personal choice learns good diet habits. Then with a glass of beer\* to brighten simple meals, he's more likely to follow a balanced maintenance diet later. And the pounds he takes off, stay off.

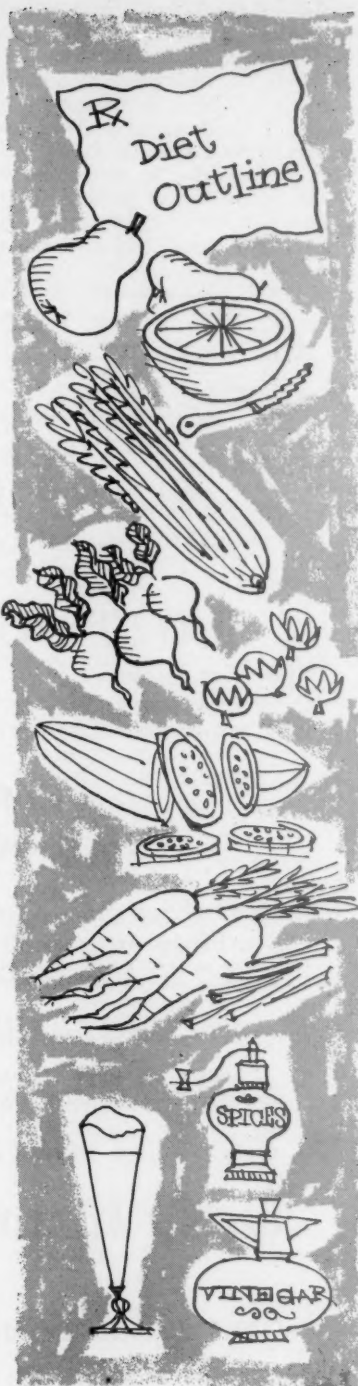


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for AUGUST, 1956



President; Dr. George F. Lull of Chicago, Secretary; Dr. J. J. Moore of Chicago, Treasurer; Dr. E. Vincent Askey of Los Angeles, Speaker, and Dr. Louis Orr of Orlando, Florida, Vice Speaker.

Dr. Julian Price of Florence, S. C., was re-elected to the Board of Trustees, and Dr. Hugh Hussey of Washington, D. C., was named to succeed Dr. Allman. Dr. Robertson Ward of San Francisco was elected to the Judicial Council to succeed Dr. Walter F. Donaldson.

Re-elected to the Council on Medical Education and Hospitals were Dr. Guy A. Caldwell of New Orleans and Dr. John W. Cline of San Francisco. Dr. Walter E. Vest of Huntington, W. Va.,

was named to succeed Dr. Louis A. Buie on the Council on Constitution and By-Laws.

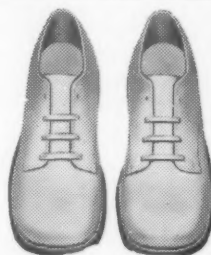
Elected to the Council on Medical Service were Dr. Carlton Wertz of Buffalo, N. Y., to succeed himself, and Dr. J. F. Burton of Oklahoma City to succeed the late Dr. A. C. Scott, Jr., of Texas. Named for the three new places created on the Council on Medical Service were Dr. Thomas Danaher of Torrington, Connecticut; Dr. R. M. McKeown of Coos Bay, Oregon, and Dr. Lafe Ludwig of Los Angeles.

GEORGE F. LULL, M.D.  
Secretary-General Manager,  
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# PROGRAM

## *Eighty-Sixth Annual Session*

### *of the*

## Colorado State Medical Society

SEPTEMBER 5, 6, 7, 8, 1956

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### *Official Call*

To the Officers, Delegates, Committeemen and Members of the Colorado State Medical Society, Greetings:

The Eighty-Sixth Annual Session of the Colorado State Medical Society will be held at the Stanley Hotel, Estes Park, Colorado, Wednesday to Saturday, inclusive, September 5 to 8, 1956.

The House of Delegates will convene at 2:00 p.m., the Board of Trustees at 3:00 p.m., and the Board of Councilors at 4:00 p.m., Wednesday, September 5, and each subsequently as by them ordered.

The General Scientific Assembly will convene at 10:00 a.m., Wednesday, September 5, and subsequently according to the Program of the Scientific Program Committee.

ROBERT T. PORTER,  
President.

Attest:

HARVEY T. SETHMAN,  
Executive Secretary  
Denver, Colorado,  
July 28, 1956.

Registration: Advance registration Tuesday, Stanley Hotel lobby, 2:00-9:00 p.m.; Stanley Manor, Wednesday, Thursday and Friday, 8:00-5:00; Saturday, 8:00-12 noon.

### WEDNESDAY, SEPTEMBER 5, 1956

#### MORNING

#### General Scientific Assembly Stanley Casino

10:00—Opening Exercises and Call to Order by Robert T. Porter, M.D., Greeley, President.

#### "Future of Medical Practice"

Samuel P. Newman, M.D., Denver,  
Presiding.

10:05—Report of A.M.A. Delegates.

for AUGUST, 1956

10:15—"Views of Labor on Medical Care"—William A. Sawyer, M.D., Rochester, New York (Guest).

10:45—"Supermarket Medicine" — Francis Hodges, M.D., San Francisco (Guest).

11:15—Intermission to Visit Exhibits.

11:45—"A Physician's Concept of the Future of Medicine"—Joseph D. McCarthy, M.D., Omaha, Nebraska (Guest).

#### AFTERNOON

12:15—Panel Discussion—William H. Halley, M.D., Denver, Moderator. Francis Hodges, M.D.; Joseph D. McCarthy, M.D.; William A. Sawyer, M.D., participating.

2:00—HOUSE OF DELEGATES — First meeting, Music Room.

### THURSDAY, SEPTEMBER 6, 1956

#### MORNING

#### General Scientific Assembly Stanley Casino

#### "Radioactive Isotopes in Diagnosis and Treatment"

Henry P. Thode, Jr., M.D., Ft. Collins,  
Presiding.

9:00—"The Rationale of Radioisotopes"—Thad Sears, M.D., Denver.

9:15—"Diagnostic and Therapeutic Use of Cobalt 60"—Robert W. Lackey, M.D., Denver.

9:30—"Radioactive Albumin in the Determination of Blood Volumes—Its Use in Clinical Medicine"—James W. Lewis, M.D., Colorado Springs.

9:45—"The Significance of Measurement of Occult and Obvious Hemolytic Anemias by Radiochromium"—Matthew Block, M.D., Denver.

10:00—President's Address — George R. Buck, M.D., Denver.

- 10:30—Intermission to Visit Exhibits.
- 11:00—"Radioactive Gold in Carcinoma of the Prostate"—Robert O. Beadles, M.D., Colorado Springs.
- 11:15—"Diagnostic and Therapeutic Applications of Radioactive Isotopes and Nuclear Radiations in Medicine"—John Lawrence, M.D., Berkeley, California (Guest).
- 12:00—Panel Discussion—J. A. del Regato, M.D., Colorado Springs, Moderator. John Lawrence, M.D.; Thad Sears, M.D.; Robert W. Lackey, M.D.; James W. Lewis, M.D.; Matthew Block, M.D.; Robert O. Beadles, M.D., participating.

#### AFTERNOON

- 2:00—HOUSE OF DELEGATES—Second meeting, Music Room.

### FRIDAY, SEPTEMBER 7, 1956

#### MORNING

#### General Scientific Assembly

Stanley Casino

#### "The Patient, The Doctor, and The Hospital"

Roy A. L. Swanson, M.D., Greeley, President, Weld County Medical Society, Presiding.

- 9:00—"Methods of Evaluating Medical Care in Hospitals" — C. Wesley Eisele, M.D., Denver.
- 9:30—"The Hospital's Responsibility to the Patient" — George Bugbee, New York City (Guest).
- 10:00—"The Generalist, the Hospital, and the A.M.A."—John S. DeTar, M.D., Milan, Michigan (Guest).
- 10:30—Intermission to Visit Exhibits.
- 11:00—"The Specialist and the Hospital"—Leland S. McKittrick, M.D., Brookline, Massachusetts (Guest).
- 11:30—"Accreditation, Its Purposes and Problems"—Kenneth Babcock, M.D., Chicago (Guest).
- 12:00—Panel Discussion—George A. Unfug, M.D., Pueblo, Moderator. Kenneth Babcock, M.D.; Leland S. McKittrick, M.D.; John S. DeTar, M.D.; George Bugbee, M.D.; C. Wesley Eisele, M.D., participating.

#### AFTERNOON

- 2:00—HOUSE OF DELEGATES — Third meeting, Music Room.

### SATURDAY, SEPTEMBER 8, 1956

#### MORNING

- 8:00—HOUSE OF DELEGATES — Fourth meeting, Election of Officers—Music Room.

#### General Scientific Assembly

Stanley Casino

#### "Neurologic Disorders"

Charley J. Smyth, M.D., Denver, Presiding.

- 9:30—"Some Ocular Manifestations of Intra-Cranial Lesions"—Paul Wetzig, M.D., Colorado Springs.
- 9:45—"Neurological Manifestations in Diabetic Children"—Donn Barber, M.D., Greeley.
- 10:00—"Current Treatment of Cerebral-Vascular Lesions"—George W. Holt, M.D., Denver.
- 10:15—Report of Neurology Committee — Frances McConnell-Mills, M.D., Chairman.
- 10:25—Summary of Actions Taken by House of Delegates.
- 10:35—Installation of New Officers.
- 10:45—Intermission to Visit Exhibits.
- 11:15—"Current Status of Poliomyelitis Vaccination Program" — Lloyd Florio, M.D., Denver.
- 11:30—Symposium on Vertigo — Homer McClintock, M.D., Denver, Moderator. Robert F. Berris, M.D., Denver; Herman I. Laff, M.D., Denver; Luman Daniels, M.D., Denver, participating.
- 12:30—Adjourn.

### THURSDAY, SEPTEMBER 6, 1956

#### MORNING

#### Indoctrination Course

- 8:45—Welcome and Explanation of the Course — Robert T. Porter, M.D., Greeley, President.
- 9:00—"Structure and Functions of Organized Medicine"—Samuel P. Newman, M.D., Denver.
- 10:00—Intermission and Question Period.
- 10:10—"Your Public Relations Are Showing"—Harvey T. Sethman, Denver, Executive Secretary.
- 10:55—"Health Insurance—Its Position in Medicine Today"—Fredrick H. Good, M.D., Denver.
- 11:55—Recess for Lunch.

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ADVERTISING PAGES 741-742 ARE MISSING.



## AFTERNOON

- 1:00—"Medical Ethics"—Leo W. Bortree, M.D., Colorado Springs.
- 1:40—"Functions of the Board of Supervisors"—William N. Baker, M.D., Pueblo, Chairman, Board of Supervisors.
- 2:25—Intermission and Question Period.
- 2:30—"Cause and Prevention of Malpractice Suits"—C. S. Bluemel, M.D., Denver.
- 3:20—"Summary of Current Medical Society Policies"—George R. Buck, M.D., Denver, President, 1956-57.
- Indoctrination Course Committee—J. Lawrence Campbell, M.D.; Fredrick H. Good, M.D.; Gunnar Jelstrup, M.D.; Paul K. Hamilton, Jr., M.D.

## FRIDAY, SEPTEMBER 7, 1956

### AFTERNOON

- 2:30—"Blue Shield Today"—Stanley Casino. Panel moderated by Dr. Fredrick H. Good, President, Colorado Blue Shield.
- I. Enrollment.
- II. Case Processing and Adjudication.
- III. Utilization and Finances.
- Question and Answer Period.
- All physicians are invited.

## PROGRAM

### WOMAN'S AUXILIARY TO THE COLORADO STATE MEDICAL SOCIETY September 5-8, 1956

#### WEDNESDAY, SEPTEMBER 5

- 10:00 A.M. - 1:00 P.M. — Registration, Stanley Manor.
- 3:00 P.M.—Tea at the home of Mrs. Jacob O. Mall.
- 6:30 P.M.—"Femme Fare" Buffet Dinner, Craggs Hotel. Mr. Pick and his fabulous jewelry. Boulder County Woman's Auxiliary in charge. Transportation will be arranged.
- 9:30 P.M.—Cards and games with the men at the Stanley Hotel.

#### THURSDAY, SEPTEMBER 6

- 9:00 A.M.-11:30 A.M.—Registration, Stanley Manor, and Pre-Convention Board Meeting. Coffee will be served at the meeting.
- 1:00 P.M.—Luncheon and Book Review by Mol-

lie Lee Beresford at Stead's Ranch. Transportation will be arranged.

- 3:00 P.M.—Work Shop for new Board members, Stanley Hotel.

## FRIDAY, SEPTEMBER 7

- 9:00 A.M.-11:30 A.M.—Registration, Stanley Manor, followed by Annual Meeting and Memorial Service by Weld County Auxiliary.
- 1:00 P.M.—Past Presidents' Luncheon and Travel Talk by Mrs. Maxwell Becker at Harmony Ranch. Laramie County Woman's Auxiliary in charge. Transportation will be arranged.
- 3:30 P.M.—Post-convention meeting, Stanley Hotel.
- 6:00 P.M.—Cocktail Hour—Pay as you go bar—Stanley Hotel.
- 7:00 P.M.—Dinner Dance, "Back to College Nite." Sports awards to be presented—Stanley Hotel.

## SATURDAY, SEPTEMBER 8

- 6:30 A.M.—Horseback Ride, Breakfast.

It is urged that all members register and wear their badges at all times in order that the Stanley Hotel will let us use all of their facilities even though some of us are not staying at the hotel.

## SPORTS EVENTS

All sports events will be held in Estes Park, with competition scheduled for Wednesday, Thursday and Friday until 4:30 p.m. Members may compete in golf, bowling and fishing. Wives of members are invited to participate in the bowling and fishing tournaments. Prizes will be awarded to the wives, too.

The golf tournament will be held at the Estes Park Golf club. Golfers can tee off Wednesday, September 5, between 1:30 p.m. and 3:30 p.m. Since this is a nine-hole course, golfers will have to play two days out of the three in order to accumulate the necessary eighteen-hole score. The entrance fee will be \$2.00. Dr. Homer S. McClintock of Denver is in charge of arrangements for this tournament.

Dr. Charles A. Carroll of Fort Collins is in charge of the fishing tournament. Lake Estes will be stocked with some big fish.

Bowling is under the direction of Dr. Jacob O. Mall of Estes Park.

Entrance fees for bowling and fishing have been set at 50 cents.

All prizes this year will be awarded at the banquet on Friday, September 7.



## FOR FREE ENTERPRISE AND FREEDOM OF CHOICE . . .

Colorado Medical Service and Colorado Hospital Service offer sincere congratulations on the outstanding success that you, the doctors and hospitals of Colorado, have made of the Blue Cross and Blue Shield Plans.

Blue Cross and Blue Shield, under your sponsorship and guidance, now serve nearly half of all the residents of Colorado. These two plans have done a great deal to maintain the principles of free enterprise in the Colorado hospital system and to maintain the freedom of the people of Colorado to choose which doctor shall serve them.

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**COLORADO MEDICAL SERVICE**

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**a unique new antibiotic  
of major importance  
PROVED EFFECTIVE AGAINST  
SPECIFIC ORGANISMS  
(*staphylococci and proteus*)  
RESISTANT TO ALL OTHER  
ANTIMICROBIAL AGENTS**



**SPECTRUM**—most gram-positive and certain gram-negative pathogens.

**ACTION**—bactericidal in optimum concentration even to resistant strains.

**TOXICITY**—generally well tolerated. This is more fully discussed in the package insert.

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**INDICATIONS**—cellulitis, pyogenic dermatoses, septicemia, bacteremia, pneumonia and enteritis due to *Staphylococcus* and infections involving certain strains of *Proteus vulgaris*, including strains resistant to all other antibiotics.

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**SUPPLIED**—250 mg. capsules of 'CATHOMYCIN', bottles of 16.

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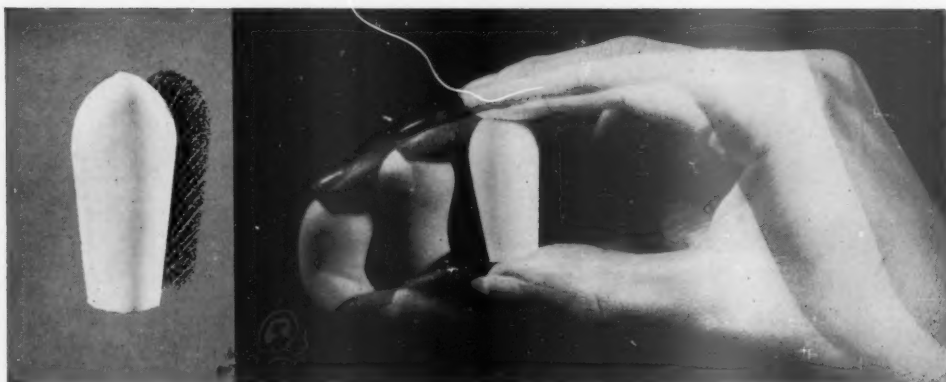
**MERCK SHARP & DOHME**  
DIVISION OF MERCK & CO., INC.  
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# Against the "Vaginitis Spectrum"

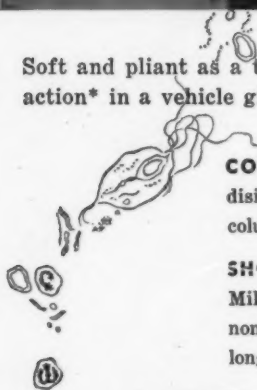


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Soft and pliant as a tampon, the Milibis vaginal suppository offers proved therapeutic action\* in a vehicle giving unusual clinical advantages to both patients and physician.



**COVERS CERVIX AND VAGINAL WALL**—The pliant Milibis suppository disintegrates readily and molds itself to the cervix as well as the columns and rugae of the vaginal vault.

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\*97 per cent effective in a study of 564 cases;  
94 per cent effective in a series of 510 cases.

Milibis (brand of glycobiarsol), trademark reg. U. S. Pat. Off.

# Dysmenorrhea:

"one third of all young women in America are afflicted with it."<sup>1</sup>

## Edrisal<sup>\*</sup>

A day or so before menstruation begins,  
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**Two tablets every 3 hours**  
Analgesic—Antispasmodic—Antidepressant

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1. M. Times 76:416.  
\*T.M. Reg. U.S. Pat. Off.



## TECHNICAL EXHIBITORS

Stanley Manor

|  | Booth No. |
|--|-----------|
| Abbott Laboratories .....                                  | 19        |
| Aloe, A. S., Company .....                                 | 22        |
| Ames Company, Inc. ....                                    | 8         |
| Audio-Digest Foundation .....                              | 7         |
| Baker Laboratories.....                                    | 2         |
| Berbert, George & Sons, Inc. ....                          | 29        |
| Boyle & Company .....                                      | B         |
| Burroughs Wellcome & Company (U.S.A.), Inc. ....           | 30        |
| Carnation Company .....                                    | 34        |
| Ciba Pharmaceutical Products, Inc. ....                    | 13        |
| Coca-Cola Company, The .....                               | 4         |
| Colorado Medical Service, Inc. ....                        | 9         |
| Darwin Laboratories .....                                  | 36        |
| Eaton Laboratories .....                                   | 6         |
| Fleet, C. B., Company, Inc. ....                           | A         |
| General Electric Co., X-Ray Department....                 | 32        |
| Lederle Laboratories, Division, American Cyanamid Co. .... | 1         |
| Lilly, Eli and Company .....                               | 10        |
| Lloyd Brothers, Inc. ....                                  | 33        |
| Mead Johnson and Company .....                             | 17        |
| Milex-Fertilex Company .....                               | 16        |
| Modern Office Machines, Inc. ....                          | 25        |
| Mosby, The C. V., Company .....                            | 5         |
| Muckle Professional Equipment Co.....                      | C         |
| Niagara of Denver .....                                    | 23        |
| Parke, Davis and Company .....                             | 11        |
| Pet Milk Company .....                                     | 15        |
| Pfizer Laboratories .....                                  | 21        |
| Physicians and Hospitals Supply Company..                  | 14        |
| Picker X-Ray Corporation of America.....                   | D         |
| Robins, A. H., Company, Inc. ....                          | 12        |
| Ross Laboratories .....                                    | 31        |
| Schering Corporation .....                                 | 28        |
| Searle, G. D., and Company .....                           | 35        |
| Sharp & Dohme, Div. of Merck and Co., Inc. ....            | 26        |
| Squibb, E. R., and Sons .....                              | 20        |
| Swift and Company .....                                    | 3         |
| Testagar and Company, Inc. ....                            | 24        |
| Warner-Chilcott Laboratories, Inc. ....                    | 18        |
| Winthrop Laboratories .....                                | 27        |

## Obituaries

### PAUL G. MATHEWS

Dr. Paul G. Mathews, 70, died in the St. Francis Hospital in Colorado Springs. He was born in Savanna, Illinois, June 16, 1886. He attended the public schools in Walsenburg and was a graduate of the Colorado University Medical School in 1908. At that time he returned to Walsenburg to engage in the practice of medicine, and continued in active practice until his last illness.

Dr. Mathews was a member of Huerfano Lodge No. 27, A. F. & A. M., of the Southern Colorado Consistory; of the B. P. O. Elks No. 1086 in Walsenburg; the Walsenburg Rotary Club, and honorary member of the La Veta Rotary Club and a Past President of the Huerfano County Medical Society.

He is survived by his wife, Edna; a daughter, Mrs. Frank Long of Boulder City, Nevada; a son, M. William Buechele of Walsenburg; a granddaughter, Paula Long; two brothers, Glen of Walsenburg and Thomas of Los Angeles, and three nephews.

### JOHN F. MACKEY

Dr. Mackey died June 21, 1956, in La Jolla, California, where he had lived since his retirement in 1954. He was born in Missouri in 1875 and was educated in that state, receiving his M.D. degree from the University Medical College in 1904.

Dr. Mackey received graduate training at Cook County Hospital in Chicago and at Mayo Clinic in Minnesota. He practiced in Missouri before moving to Denver in 1943. He was a member of the American Medical Association and of the Denver and Colorado State Medical Societies.

Survivors are his widow, Nell; a daughter, Martha, and a son, Dr. John F. Mackey, Jr., of St. Louis.

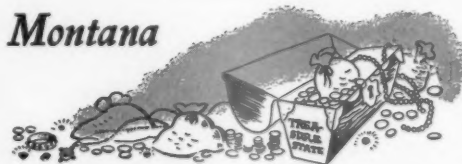
### CHESMORE EASTLAKE

Dr. Eastlake was stricken by a heart attack in the Republic Building June 20, 1956, and was dead by the time he reached St. Joseph's Hospital in an ambulance.

He was born in 1892 in St. Joseph, Missouri, and received his early education in Missouri schools. He graduated from the University of Colorado School of Medicine in 1922 and had practiced in Colorado ever since, specializing in internal medicine. He was a member of the Colorado State Medical Society and of the Denver Medical Society.

Dr. Eastlake is survived by his widow, Lorraine, of 300 Dahlia Street, and a son, Dr. Chesmore Eastlake, Jr., of California.

## Montana



### SEVENTY-EIGHTH ANNUAL MEETING MONTANA MEDICAL ASSOCIATION

The Seventy-Eighth Annual Meeting of the Montana Medical Association and the Seventh Annual Meeting of the Great Falls Medical-Surgical Conference will be held in Great Falls, Montana, Thursday, Friday, and Saturday, September 13, 14, and 15. All of the scientific and business sessions as well as the technical and scientific exhibits will be held in the newly refurbished meeting rooms on the first floor of the new Hotel Rainbow.

The scientific sessions will be held on Thursday, Friday, and Saturday between the hours of 9 a.m. and 3:30 p.m.; meetings of the House of Delegates will be held on each of these three days immediately following the adjournment of the scientific sessions. These business meetings of the House of Delegates of the Association will

# *Welcome to the* **New Stanley Hotel**

Estes Park

Headquarters for the  
86th Annual Session of the  
**COLORADO STATE MEDICAL SOCIETY**  
September 5-8

The Stanley Hotel is proud to be convention headquarters for the annual session of the Colorado State Medical Society and extends a warm welcome to its members and to the Woman's Auxiliary.

The Stanley Hotel management promises you a pleasant time during your stay September 5 to 8.

Please make reservations now.

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R. W. Dean, Manager

continue until approximately 6 p.m. on each day.

Among the scientific speakers who will be featured at this joint meeting of the Montana Medical Association and the Great Falls Medical-Surgical Conference will be:

Frederic C. Bost., M.D., Clinical Professor of Orthopedic Surgery, University of California School of Medicine.

Michael E. DeBakey, M.D., Professor of Surgery, Baylor University College of Medicine.

Stanton A. Friedberg, M.D., Clinical Associate Professor of Oto-Laryngology, University of Illinois College of Medicine.

Eleanor M. Humphreys, M.D., Professor of Pathology, University of Chicago, The School of Medicine.

Arthur J. Jampolsky, M.D., Assistant Clinical Professor of Surgery (Ophthalmology), Stanford University School of Medicine.

Charles E. McLennan, M.D., Professor of Obstetrics and Gynecology, Stanford University School of Medicine.

Max Miller, M.D., Associate Professor of Medicine, Western Reserve University School of Medicine.

Burtrum C. Schiele, M.D., Professor of Psychiatry, University of Minnesota Medical School.

The scientific program will include several clinical-pathological conferences and a symposium upon a scientific subject of importance to physicians in general practice.

On Thursday evening, September 13, the Association will hold its annual reception and banquet. The banquet will feature a nationally-known speaker who will present an address of importance upon a subject of current interest to the profession. In addition, Montana physicians who have been engaged in the active practice of medicine for fifty years or more will be honored at the banquet as new members of the Fifty Year Club of the Association. On Friday evening, September 14, the Cascade County Medical Society will be host to Montana physicians and their guests at an unusual program of entertainment at the Meadowlark Country Club in Great Falls.

All Montana physicians as well as all physicians in the Rocky Mountain area and in Canada are cordially invited to attend this meeting. The new Hotel Rainbow with its continental atmosphere, soft music and lights, sparkling gaiety, will offer a delightful meeting place where physicians and their wives from this area may meet their colleagues. A copy of the final program will be mailed to physicians upon request to the Montana Medical Association, P. O. Box 1692, Billings, Montana.

# PROGRAM

## *Sixty-First Annual Session*

### *of the*

## Utah State Medical Association

SEPTEMBER 5, 6, 7, 8, 1956

SALT LAKE CITY, UTAH

Headquarters: Hotel Utah

### WEDNESDAY, SEPTEMBER 5

#### MORNING

8:00 A.M.-5:00 P.M.—House of Delegates, Utah State Medical Association, Junior Ballroom, Hotel Utah.

#### EVENING

6:30—Annual Meeting, Dinner and Reception of Medical Service Bureau of Utah State Medical Association, Inc. (Blue Shield). No formal speeches. Election of directors and officers. All participating members are invited to be guests of Blue Shield.

### THURSDAY, SEPTEMBER 6

#### MORNING

Chairman: R. O. Porter, President, Utah State Medical Association.

8:00—Motion Pictures—"Repair of Inguinal Hernia," by Francis D. Moore, M.D.; "Cooper's Ligament Herniorrhaphy for Indirect Hernia, Associated Direct Hernia," by Jack Farris, M.D., Los Angeles.

9:00—Welcome by R. O. Porter, M.D., President, Utah State Medical Association.

9:10—"The Surgical Approach to Ulcerative Colitis," by Mark M. Ravitch, M.D., Johns Hopkins Hospital, Baltimore, Maryland.

9:30—"The Management of Abdominal Aortic Aneurysms," by Harris B. Schumacker, Jr., M.D., Professor of Surgery, Indiana University.

9:50—"Problems of Shoulder and Arm Pain," by R. K. Ghormley, M.D., Senior Consultant, Mayo Clinic, Rochester, Minnesota.

10:30—Recess to Visit Exhibits.

10:50-12:00—"Symposium on Intestinal Obstruction," Russell M. Nelson, M.D., Moderator. Panel consisting of Philip B. Price, M.D.; Kenneth B. Castle-

ton, M.D.; Ralph C. Richards, M.D.; Dean W. Tanner, M.D.; John A. Gubler, M.D.; Wm. R. Christensen, M.D.; and C. R. Openshaw, M.D.

12:00—Recess for Luncheon.

ROOF GARDEN—Panel discussion on Internal Medicine, Drew M. Peterson, M.D., Moderator, with Lowell A. Rantz, Professor of Medicine, Stanford University; M. M. Wintrobe, Head of the Department of Internal Medicine, University of Utah, and Hugh Hare, Radiologist, Los Angeles, participating as panel members.

JUNIOR BALLROOM—Panel discussion on Obstetrics and Pediatrics, E. G. Holmstrom, M.D., Moderator, with Drs. Russell de Alvarez, University of Washington, and Robert Aldrich, Professor of Pediatrics, University of Oregon.

#### AFTERNOON

Chairman: John H. Clark, M.D., President, Salt Lake County Medical Association.

2:00—"The Modern Management of Rheumatic Fever," by Lowell A. Rantz, M.D., Professor of Medicine, Stanford University, San Francisco.

2:20—"Bleeding of Late Pregnancy," by Russell R. de Alvarez, M.D., University of Washington.

2:40—"Voluntary Prepayment Insurance at the Crossroads," by Mr. Harry Becker, Consultant on Prepaid Health Care Plans, Chicago.

3:00—Recess to Visit Exhibits.

3:20-4:40—SPECIALTY GROUP MEETINGS.

Surgery—Lafayette Ballroom—Chas. Woodruff, M.D., Chairman.

Obstetrics-Gynecology—Junior Ball-

room—Fred Kartchner, M.D., Chairman.

Orthopedics—President's Suite — A. M. Okelberry, M.D., Chairman.

#### EVENING

This date has been left open for dinner parties sponsored by various specialty groups, with invited guest speakers as guests. (Ladies included at all parties.)

#### FRIDAY, SEPTEMBER 7

##### MORNING

Chairman: Merrill C. Daines, President, Cache County Medical Society.

- 8:00—Motion Pictures. "Fractures About the Wrist and Hand" and "Precautions in Resection of the Colon for Carcinoma," by Warren H. Cole, M.D., Chicago.
- 9:10—"Modern Treatment of Urinary Infection," by Henry Weyrauch, M.D., Stanford Hospital, San Francisco.
- 9:30—"The Present Status of Tuberculosis in Childhood," by Robert A. Aldrich, M.D., Associate Professor of Pediatrics, University of Oregon.
- 9:50—"Radiation Treatment of Carcinoma of the Breast," by Hugh H. Hare, M.D., Los Angeles Tumor Institute.
- 10:10—"The Use of Hormones in the Female," by Russell de Alvarez, M.D.
- 10:30—Recess to Visit Exhibits.
- 10:50-12:00—"Current Topics in Internal Medicine," Symposium sponsored by the Department of Medicine, College of Medicine, University of Utah; M. M. Wintrobe, M.D., Moderator.
- 12:00—Recess for Luncheon.

**JUNIOR BALLROOM**—Panel discussion on Surgery, Wallace S. Brooke, M.D., Moderator, with Drs. Mark M. Ravitch, Harris B. Schumacher, Jr., and Russel Nelson, Assistant Professor of Surgery, University of Utah.

**PRESIDENT'S SUITE**—Discussion on Pediatrics with Dr. Robert A. Aldrich, Associate Professor of Pediatrics, University of Oregon, and James F. Bosma, M.D., Professor and Head of the Department of Pediatrics.

**PIONEER ROOM**—Discussion on Urology with Dr. Henry Weyrauch.

##### AFTERNOON

Chairman: C. M. Smith, M.D., President, Utah County Medical Society.

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WHO SUFFERS  
IN THE  
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enough salt to make food  
palatable; without them,  
many patients would lose  
their appetites, a conse-  
quence of the salt-free diet  
which has occasionally been  
known to cause serious  
malnutrition."\*

\*Modell, W.: The Relief of Symptoms, Phil-  
adelphia, W. B. Saunders Company, 1955,  
pp. 265-266.

02188

2:00—Mr. Harry Becker.

2:20—"The Clinical Significance of Anti-  
biotic (Resistant) Bacteria," by Lo-  
well A. Rantz, M.D.

2:40—"The Doctor's Responsibility to the  
Hearing Handicapped," by Dr. How-  
ard House, Los Angeles.

3:00—Recess to Visit Exhibits.

3:20-4:40—SPECIALTY GROUPS.

Internal Medicine—Lafayette Ball-  
room—Leonard Jarcho, M.D., Chair-  
man.

Pediatrics—Junior Ballroom—War-  
ren Tepper, M.D., Chairman.

Urology—President's Suite—Robert  
G. Weaver, M.D., Chairman.

Radiology—Pioneer Room—Wm. R.  
Christensen, M.D., Chairman.

Eye, Ear, Nose and Throat—Robert  
Snow, M.D., Chairman.

#### EVENING

6:00-7:00—President's Reception, Alta Club.

7:15—President's Banquet, Lafayette Ball-  
room, Hotel Utah. Principal Speaker,  
Dwight Murray, M.D., President of  
the American Medical Association.  
Subject: "Medicine, Past, Present  
and Future."

Entertainment to follow.

#### SATURDAY, SEPTEMBER 8

##### MORNING

Chairman: B. Kent Wilson, M.D., President,  
Carbon County Medical Society.

8:00—Motion Pictures. "Surgery of the  
Biliary Tract," by Ralph Bettman,  
Chicago; "Visible Mouth Lesions," by  
Eugene S. Hopp, M.D., and Lewis F.  
Morrison, M.D., San Francisco.

9:10—"Malignant Tumors in Infants and  
Children," by Mark M. Ravitch, M.D.

9:30—"The Treatment of Chronic Pericar-  
dia Constriction," by Harris B. Shu-  
macker, Jr., M.D.

9:50—"The Present Status of Surgery of the  
Hip Joint," by R. K. Ghormley, M.D.

10:10—Recess to Visit Exhibits.

10:30—"Lymphomas—Diagnosis and Treat-  
ment," by Hugh Hare, M.D.

10:50—"The Significance and Management  
of Acute Nephritis Today," by Robert  
A. Aldrich, M.D.

11:10—"Common Ear Problems and Their  
Management," by Howard P. House,  
M.D., Los Angeles.

11:30—"Prostatic Paradoxes," by Henry M.  
Weyrauch, M.D.

ROCKY MOUNTAIN MEDICAL JOURNAL

## New Mexico



### ABSTRACT OF MINUTES

of the

### HOUSE OF DELEGATES

### NEW MEXICO MEDICAL SOCIETY

Annual Session—Roswell, New Mexico

#### FIRST SESSION

Tuesday, May 1, 1956

President Earl L. Malone, Roswell, called the House to order at 8:00 p.m., May 1, 1956, and recognized Dr. Lewis M. Overton, Secretary-Treasurer, for the purpose of calling the roll of Delegates.

Forty-four delegates (more than a quorum) answered the roll call; only two delegates were absent.

On motion the minutes of the previous meeting of the House were approved.

The floor was accorded to Tom Calkins, Ph.D., Chairman of the Governor's Council for the Employment of the Physically Handicapped, for the purpose of presenting a plaque to Dr. Stuart W. Adler, Albuquerque (in the name of the President of the United States), for his outstanding service in contributing to the employment of the handicapped.

Dr. Adler expressed his pleasure over the plaque and how satisfying working with the physically handicapped had been.

#### Supplemental Report of the Council

At a meeting held today, the Council approved the following recommendations for your consideration:

1. That the application for membership-at-large of Dr. John T. Boldrick, Clayton, be approved.

2. That the following members be elected to Emeritus Membership: Frederick G. Fox, M.D., Albuquerque; Edgar B. Beaver, M.D., Gallup; Leroy J. Bowers, M.D., Las Cruces; H. S. Alexander, M.D., Santa Fe, and Legrand Ward, M.D., Santa Fe.

3. That the following amendments to the By-Laws be approved.

(a) Chapter 1, Sec. 1 (c): Delete the word, "illness," after "financial hardship," delete remainder of sentence and add, "are unable to pay their dues, or who have retired from active practice."

(b) Chapter IV, Sec. 2: After "the members," add: "in good standing who have paid their dues and emeritus members."

(c) Chapter IX, Sec. 12: After "Society" delete remainder of sentence and add in lieu thereof, "by the First of March."

(d) Chapter IX, Sec. 13: Complete Section deleted, and reword, as follows: "Any County Society which, by the First of March, has failed to make the required report or to pay the pro rata assessment from each member from whom dues have been collected, shall be held as suspended, and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the House of Delegates."



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for AUGUST, 1956

4. That the following nominees for the General Practitioner Award for 1956 be considered: Tobias Espinosa, M.D., Espanola; Ethelbert J. Hubbard, M.D., Dexter.

5. That the legal counsel be placed on a retainer fee of \$150.00 per month for the next year.

6. That the following resolution be adopted: WHEREAS, It is the expressed philosophy of the State Medical Society that the diagnosis and treatment of patients is the sole right and responsibility of private practicing physicians;

THEREFORE, BE IT RESOLVED, That the present Medical Advisory Committee to the State Department of Public Health be hereafter designated as the Public Health Committee of the State Medical Society and be expanded to include five members to be charged with the present duties of the Advisory Committee to the State Department of Health and with the consideration of any other matters in the realm of Public Health having any bearing on the interest of the medical profession, and particularly the defining of the proper spheres of activity of the State Department of Public Health;

BE IT FURTHER RESOLVED, That the Public Health Committee of the State Medical Society be instructed to exercise continuing review of the operation of the State Department of Health and be prepared to recommend curtailment, alteration, or expansion of programs.

7. That the House consider the following resolution:

WHEREAS, The New Mexico Society for Crippled Children and Adults and other interested private non-profit agencies are sponsoring the establishment and operation of a Rehabilitation Center in Albuquerque;

WHEREAS, The Center is to serve the entire State of New Mexico;

WHEREAS, The Center will furnish services for all disabilities for which it has facilities;

WHEREAS, The medical services in the Center, namely: Medical evaluation, formulation of the re-

habilitation program and periodic review of the program of each patient shall be furnished by members of the New Mexico Medical Society;

THEREFORE, BE IT RESOLVED, That the New Mexico Medical Society endorse the principle of the project and that the President be instructed to appoint an Advisory Committee approved by the Council to work with the sponsors in setting up the medical program for the rehabilitation center.

8. That the financial report of the Secretary-Treasurer, which had been audited by Linder, Burk and Stephenson, C.P.A., be approved.

#### Published Council Report

The President called for action concerning the Council Report, which had previously been submitted to the Delegates in mimeographed form.

Dr. Guy Rader stated that in the published Council Report, the Council had recommended that compulsory membership to the AMA be presented to the House of Delegates with recommendation for passage. Motion was duly made and seconded that this portion of the Council Report be not approved, and carried without dissent.

The published Council Report, as amended, was approved as submitted, without dissent.

The President announced that that portion of the Supplemental Council Report which concerns amendments to the By-Laws and the resolutions on a rehabilitation center and the Public Health Committee will be discussed at the Second Session. Therefore, items numbered 1, 2, 4, and 5 are open for discussion at this time.

On motion duly seconded, items number 1 and 2 were approved without dissent.

On motion duly made and seconded, Dr. Tobias Espinosa was elected to receive the 1956 General Practitioner's Award under item number 4.



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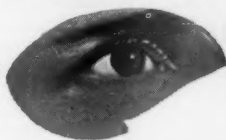
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Item number 5 was approved without dissent, placing Mr. Howard Houk, legal counsel, on a retainer fee of \$150.00 per month for the next year.

### Journal Report

Mr. Harvey T. Sethman, Managing Editor, ROCKY MOUNTAIN MEDICAL JOURNAL, was introduced for the purpose of giving a report on the JOURNAL. Mr. Sethman reported that the JOURNAL had made improvements in certain type styles, which changed and improved readability. All scientific material submitted by New Mexico had been printed or is in the process of being printed. Advertising in the JOURNAL is still on the increase; it is in very good condition financially, which assures no necessity of increasing subscription rates, which have not been increased since 1926.

### Published Committee Reports

The President called for discussion of printed committee reports and supplemental reports of committee chairmen, as follows:

AMERICAN MEDICAL EDUCATION FOUNDATION: Dr. E. W. Lander, Chairman, reported that since his report was published, he had received a bulletin announcing the Ford Foundation's program for matching funds received by AMEF to a maximum of two million dollars per year. Dr. Lander stressed the importance of donating through the AMEF and moved that five dollars of the present State Society dues be allocated to AMEF annually; that this State contribution undesignated; that this proposition be authorized for one year only; that this proposition be null and void if subsidized by an assessment of the same amount of money by the AMA for the same purpose. Motion was duly seconded and defeated.

ADVISORY COMMITTEE TO STATE HEALTH DEPARTMENT: Dr. Stuart W. Adler, Chairman, asked that in recommendation number one in his published committee's report, that the word "accepted" be changed to read "noted" and that the resolution pertaining to the Medical Advisory Committee to the State Health Department, which was recommended favorably to the House by the Council, be appended to this report. After considerable discussion Dr. Aaron Margulis was accorded the floor for the purpose of reading a letter for the record from the New Mexico Association of Radiologists and Pathologists:

House of Delegates,  
New Mexico Medical Society:

A committee of the New Mexico Society of Radiologists and Pathologists has studied the proposals of Dr. Leland regarding the extension of Public Health laboratories throughout the State, and has reviewed his stated major objectives. Our group emphatically reiterates that at no time will it condone tactics obstructing improvement in medical service and practice, and that its prime interests are bringing specialized aids to the physician serving the sick and disabled.

We assert that clinical pathologists and radiologists are necessary adjunct physicians in the modern practice of medicine, and we view with satisfaction the spread of these services over our State in the past decade, due in large measure to the opportunity for unique service presented by this hitherto medically sparsely settled territory.

We believe that the criterion for transferring a service from a private to a public function is "will it be done better and/or more economically?" It is obvious that a laboratory manned by non-medical personnel or an x-ray machine manipulated by a technician are in no way professional substitutions for physicians especially trained in these fields. We therefore view with alarm any development that discourages the establishment of, or undermines the

presence of, highly qualified professional services by inadequate substitutes.

We have no quarrel with functions legislatively conferred by society upon governmental officials with regard to legitimate public health protective devices, which transcend individual objectives. But we view with deep concern any possible inroads upon the private practice of medicine, and we ask your combined vigilance, even though the intrusion is only nibbling at a peripheral, though vital, group.

We note that the proposed program of our State Health Department has been copied from the stated objectives of the United States Public Health Service, and with these there can be no local discussion. But we also note that there have already occurred in New Mexico, in our opinion, major errors of conduct, concept and interpretation, with disquieting implications. We are also appalled by the apparent disinterest in utilizing already established competent services in preference to the extensive and expensive building, the ever difficult adequate staffing of new establishments that duplicate those already operating. Utilizing established private service will retain and attract competent physicians, while duplication will discourage them. There are many other statements by the Health Department regarding intent and plans that we find vague and, indeed, of dubious propriety.

Plans based upon the supposed need for supplying services which indigents cannot afford are fallacious. The members of our Society stand ready to contribute their services, as have our clinical colleagues, to the needy, regardless of their ability to pay. The Public Health Department can do this only at great public cost, which burden we share in the end. Incredibly, a major figure in our State Public Health organization stated to me in my office, "We can perform 'such and such' services in unlimited form because we do not have to consider costs!"

Finally, we strongly urge close watch upon future plans and actions of the Health Department, and petition that a member of our association be appointed to the public health committee to help in serving its function of protecting the public weal. Respectfully submitted, Martin B. Goodwin, M.D., Chairman, William Hentel, M.D., and Aaron E. Margulis, M.D., for the New Mexico Association of Pathologists and Radiologists.

After considerable discussion Dr. A. S. Lathrop moved that the report of the Advisory Committee to the State Health Department, as amended, and the resolution pertaining to the Advisory Committee to the State Health Department, and the report from the New Mexico Association of Radiologists and Pathologists, be approved. Motion was duly seconded and carried without dissent.

**MATERNAL AND INFANT MORTALITY COMMITTEE:** Dr. Guy Rader moved that the report be approved as published. Motion was duly seconded and carried without dissent.

**INSURANCE COMMITTEE:** Dr. Omar Legant, Chairman, requested that item 3 in his committee's report be submitted as a resolution, as follows:

WHEREAS, Frequent instances arise in workmen's compensation cases in which opinions of members of the medical profession have varied widely as to diagnosis, proposed treatment and disability rating of the same cases:

WHEREAS, This has not contributed to a feeling of confidence in the Medical Profession, particularly when such widely disparate medical testimony is aired in court:

BE IT RESOLVED, That the Insurance Committee be authorized to make a study toward possible formation of a Medical Review Board whose function would be to review cases in which there is conflicting medical testimony and render its own opinion.

Dr. Legant moved the adoption of this portion of his report which was duly seconded and carried, with one dissenting vote.

The Committee Chairman, Dr. Legant, requested permission to substitute the following motion for item number 4 in his report: "I move that an average fee schedule for treatment of injuries be drawn up by a committee appointed by the President of the Society and that the fee

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\*Moyer, J. H., and others:  
J. Chronic Dis. 2:670, 1955.

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schedule be returned to the Council or House of Delegates for approval. If such approval is received, then such fee schedule should be deposited with the Executive Secretary in the State Office for the use of insurance adjusters.” Motion was duly seconded.

Dr. Overton amended the motion, that the fee schedule be for use of insurance adjusters “and doctors.” The amendment was agreed to by the sponsors of the primary motion and was duly seconded.

Dr. C. G. Bunch moved a further amendment that this fee schedule be revised annually. This motion was acceptable to sponsors of the primary motion and was seconded.

Motion, as amended, was defeated.

Dr. Legant moved that his committee report, as amended, be approved. Motion was duly seconded and carried without dissent.

**ADVISORY COMMITTEE TO THE STATE WELFARE DEPARTMENT:** Dr. Stuart W. Adler was accorded the floor for the purpose of presenting the following message: “At the request of the Council I was asked to reaffirm the time-honored principle that all State Medical Society Committees report their activities and recommendations to the House of Delegates or the Council for confirmation or revision before their implementation, except when authorized to act.”

Dr. W. L. Minton moved the report of the Advisory Committee to State Welfare Department be approved and it was duly seconded and carried without dissent.

On motion duly seconded and carried, the following committee reports were approved as published:

**PUBLIC RELATIONS COMMITTEE**

**BOARD OF SUPERVISORS**

**REPORT OF DELEGATE TO AMERICAN MEDICAL ASSOCIATION**

**CONVENTION COMMITTEE**

**ADVISORY COMMITTEE TO SELECTIVE SERVICE**

**CONTINUING COMMITTEE, ROCKY MOUNTAIN MEDICAL JOURNAL.**

**NEW MEXICO PHYSICIANS' SERVICE**

**LEGISLATIVE COMMITTEE:** Dr. R. C. Derbyshire was accorded the floor to introduce a resolution, which was a supplemental report of his committee, as follows:

WHEREAS, It has come to the attention of the Secretary of the New Mexico Board of Medical Examiners that as a result of the work of the committee of the legislature investigating its State Boards, that the committee will recommend to the legislature that a State Department of Licensure be established as recommended by the Little Hoover Commission in 1954;

WHEREAS, It is believed that the problems of the New Mexico Board of Medical Examiners are such that they cannot be efficiently handled by anyone other than physicians;

BE IT RESOLVED, That the House of Delegates instruct the Legislative Committee to resist any attempt of the Legislature to place the New Mexico Board of Medical Examiners under a Department of Licensure and to make every effort to leave the administration of the Board entirely in the hands of physicians as represented on the New Mexico Board of Medical Examiners.

Dr. C. P. Bunch moved the adoption of the resolution and acceptance of the Committee Report. Motion was duly seconded and carried without dissent.

**HOSPITAL LIAISON COMMITTEE:** Inasmuch as this report was not published, Dr. Overton,

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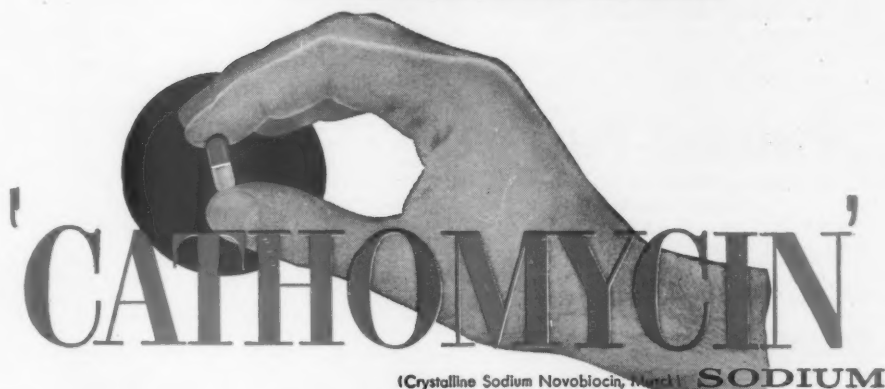
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Chairman, read his report which was duly approved without dissent.

**MENTAL HEALTH COMMITTEE:** Dr. Stuart Adler pointed up that he wished to introduce a resolution spelling out one of the recommendations of this committee, as follows:

Resolved, That the Mental Health Committee of the State Medical Society shall concern itself with any or all phases of mental health coming to its attention and shall through its chairman represent the Society on the Governor's Advisory Committee on Mental Health. In addition, the Mental Health Committee shall serve as the Advisory Committee to the New Mexico Commission on Alcoholism.

Dr. Guy Rader moved the adoption of this resolution and the report as a whole which was duly seconded and carried without dissent.

A resolution sponsored by the Bernalillo County Medical Society and submitted to the delegates with the committee reports was discussed, and Dr. Guy Rader presented the following amendment to the resolution:

That in all instances in the Constitution and By-Laws where "Board of Supervisors" is mentioned, that the name "Grievance Committee" be substituted.

Motion was duly seconded.

The President reminded the Delegates that since this resolution amended the Constitution, that it would have to lay on the table for one year and this resolution will be voted on at the next Annual Session.

Dr. C. P. Bunch was accorded the floor to introduce a motion which pertained to the above resolution, as follows:

That at next year's House of Delegates' meeting, if the above amendment to the Constitution is passed, that three members be elected for three years, and two members be elected for two years; that at the subsequent annual session of the House of Delegates, three members be elected for three years and one for one year, and that at each subsequent annual meeting of the House of Delegates, three members be elected for three years.

Motion was duly seconded and carried without dissent.

**Constitutional Amendments**

The President reported that the following Constitutional amendments have lain on the table for one year and are now ready for action:

1. "Article VII.—Council. The Council shall consist of six Councilors, one from each Councilor District, the President, President-Elect, Vice President, immediate past President, and Secretary-Treasurer. The Delegate to the American Medical Association is urged to attend the meetings of the Council in an ex-officio capacity."

"Besides its duties mentioned in the By-Laws, it shall constitute the Finance Committee of the House of Delegates. Six voting members of the Council shall constitute a quorum."

On motion duly made and seconded, this amendment was approved without dissent.

2. "Article VI.—Officers.

"Section 1. The officers of the Society shall be a President, a President-Elect, a Vice President, a Secretary-Treasurer, and six Councilors."

"Section 2. The President, President-Elect, and Vice President shall be elected annually; the Secretary-Treasurer shall be elected for a term of two years; and the Councilors shall be elected for a term of three years, two councilors therefore shall be elected annually. All these officers shall serve until their successors are elected and installed."

"Section 3. Upon the death or inability to serve of any officer or Councilor, the President shall appoint, upon the advice of the Council, some member from the Society to serve out the term of the deceased until the next Annual Meeting."

On motion duly made and seconded, this Constitutional amendment was approved without dis-

sent. Thus all Constitutional amendments as submitted were approved without dissent.

Dr. Stuart Adler was recognized for the purpose of offering a further amendment to the newly amended Article VI., of the Constitution, Section 3, as follows: That "or incapacitated" be added after the word "deceased" in the first line. Motion to amend was duly seconded and carried without dissent. (This amendment will be voted on at the next Annual Session.)

The President announced that the House was now open for new business which will be voted on at the next meeting of the House.

Dr. J. C. Sedgwick moved that either the Public Relations Committee or a special committee be appointed to try to work out a program with the State Bar Association concerning a Standard of Practice Governing Doctors and Lawyers. Motion was duly seconded.

Dr. Wendell Peacock moved that a seventh Council District be created to include the areas of McKinley and San Juan Counties. Motion was duly seconded.

Dr. E. W. Lander, Chairman, Nominating Committee, reported that Dr. Albert Simms has resigned from New Mexico Physicians' Service, and therefore, it would be necessary to nominate someone from the floor to serve out his unexpired term.

The President called for nominations for any offices from the floor, in addition to the Nominating Committee report.

Dr. John Conway nominated Dr. R. C. Derbyshire, Santa Fe, to the Council, for District 2.

There being no further business, the President declared the first session of the House adjourned until 8:30 a.m. Wednesday, May 2, 1956.

## SECOND SESSION

Wednesday, May 2, 1956

The President called the second session to order at 8:30 a.m., and recognized the Secretary-Treasurer.

The Secretary-Treasurer, Dr. Overton, announced that a quorum was present with 40 of the 44 Delegates seated.

The President reported the first order of business would be a discussion of amendments to the By-Laws as presented at the first session. On motions duly seconded, all amendments were passed without dissent.

The next order of business would be discussion on new business which was introduced at the first session as follows:

1. Motion of Dr. Sedgwick's to have the Public Relations Committee or a special committee try to work out a program with the Bar Association concerning a Standard of Practice Governing Doctors and Lawyers. Motion carried without dissent with a suggestion that the Public Relations Committee function in this regard.

2. Resolution of Dr. Derbyshire's disapproving of placing the Board of Medical Examiners under a department of licensure headed by a political appointee for all licensing boards and requesting the Legislative Committee to strongly oppose any effort along this line by the legislature. Motion carried without dissent.

3. Resolution of Dr. Overton's calling for endorsement by the State Society of the principle of establishing and operating a rehabilitation center in Albuquerque by the New Mexico Society for Crippled Children and Adults. Motion carried without dissent.

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4. Motion of Dr. Peacock's calling for redistricting of Councilor Districts. Dr. Peacock requested that his original motion be withdrawn for the purpose of introducing a substitute motion, which was granted. His new motion is as follows: "I move that the Council be instructed to redistrict the State, based on geographical convenience, if possible, to include making Bernalillo County one district and to give all counties representation on the Council." The new motion was duly seconded and carried without dissent.

**Constitutional Amendments**

The President pointed up that with the passage of this motion, certain changes in the Constitution would have to be made in order to comply with the motion, and that these amendments would have to lay on the table one year.

Dr. Stuart Adler was recognized for the purpose of introducing some amendments to the Constitution to effectuate Dr. Peacock's motion, as follows:

"I move that Article VII.—Council, be amended to read, 'The Council shall consist of one Councilor from each Council District,' instead of 'The Council shall consist of six councilors, one from each Council District.'" Motion was duly seconded.

"I move that Article VII. (second paragraph), be further amended, as follows: 'Six voting members of the Council shall constitute a quorum,' shall be changed to read, 'The majority of voting members of the Council shall constitute a quorum.'" Motion was duly seconded.

"I move that Article VI.—Officers, Sec. 1, '... and six Councilors,' be changed to read, '... and the Councilors.'" Motion was duly seconded.

Dr. J. C. Sedgwick was accorded the floor and introduced the following additional amendment to the Constitution:

That Article VI.—Officers, Section 2, be changed from: "... two Councilors therefore shall be elected annually," to "... one-third of the Councilors therefore shall be elected annually." Motion was duly seconded.

Dr. George Prothro was recognized for the purpose of introducing some new business and making a motion pertaining thereto. "I move that Dr. Hal Miller, Clovis, be elected to emeritus membership by virtue of his illness and retirement." Motion was duly seconded and carried.

**Election of Officers**

The President announced that election of officers would now transpire and called for nominations for any office.

Dr. J. C. Sedgwick stated that in view of Dr. John Conway's faithfulness for many years as President of New Mexico Physicians' Service, and for his fine ability in this capacity, he would move that Dr. Conway be nominated for membership on the Board of Trustees, NMPS.

Dr. John Conway stated that he very much appreciated the nomination, but that since he had served on the Board for many years, and due to demands on his time, he would like to withdraw his nomination, but that if he could be of service at any time to the Board from his past experience, he would be glad to assist in any way.

Dr. Guy Rader moved that nominations be closed which was duly seconded and carried.

The President appointed four tellers and asked that the election ballots be distributed.

**Introduction of New President**

The President then stated: "It now gives me pleasure in many respects and considerable con-

fidence in the State Society for the coming year to have the new President, Dr. Stuart W. Adler, Albuquerque, escorted to the chair."

Having received the gavel, Dr. Adler stated, in part: "I accept your kind offer to entrust the operation of this Society so far as the Presidency is concerned to me for the coming year."

"I think it is probably appropriate not only for the general meeting, but for this meeting to tell you that I think Dr. Malone deserves special credit during the past year for having taken over the duties of President on rather short notice. You gentlemen very graciously took into consideration my indisposition of last year, when there was considerable question as to whether I would be able to serve any office again. My good fortune is apparent by my presence here, due to the fact that you saw fit to hold over my status as President for the coming year. This was one of the finest tributes I have received. I was honored that you were willing to wait. Because of that fact, Earl (Malone) got his job unprepared, on short notice, and I think the progress during the last year of the Society is evidence of his capability. He has done an excellent job, and I want to pay personal tribute to him under those circumstances."

#### New Business

A letter was received from the New Mexico Tuberculosis Association requesting the Society to appoint a committee to help establish a policy for chest x-rays taken by private physicians. Letter was referred to Public Health Committee.

Delegates from Bernalillo and Dona Ana County extended invitations for the 1958 Annual Session to be held in Albuquerque and Las Cruces.

The New Mexico Science Fair was discussed and Dr. J. A. Evans moved that the House of Delegates request the Public Relations Committee to take definite action in offering awards for biological exhibits at next year's Fair; that the Science Fair Board be requested to appoint a member of the Society to serve on the Biological Sciences Committee, and that the Public Relations Committee be authorized to expend a sum in the amount of \$200.00 for exhibit awards. Motion duly seconded and carried, without dissent.

Dr. Adler introduced the following resolution:

"BE IT RESOLVED, That the Delegates to the 74th Annual Session to the New Mexico Medical Society, in behalf of the doctors and the wives, extend their appreciation to the Chaves County Medical Society for this successful meeting."

Motion duly seconded and heartily carried.

Dr. H. J. Beck, on behalf of the Delegates, expressed appreciation to the Executive Secretary and his wife.

#### Report of Election

The President announced that the tellers' report of the election is as follows:

President-Elect: Samuel Ziegler, M.D., Espanola.

Vice President: J. C. Sedgwick, M.D., Las Cruces.

Councilman, District 1: J. A. Evans, M.D., Las Vegas.

Councilman, District 2: Aaron Margulis, M.D., Santa Fe.

Delegate to AMA: H. L. January, M.D., Albuquerque.

Alternate Delegate: Earl L. Malone, M.D., Roswell.

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**GYNECOLOGY AND OBSTETRICS**—Obstetrics and Gynecology, Three Weeks, October 22. Office and Operative Gynecology, Two Weeks, September 17. Vaginal Approach to Pelvic Surgery, One Week, September 10.

**MEDICINE**—Electrocardiography & Heart Disease, Two Week Basic Course, October 8; One Week Advanced Course, September 17. Internal Medicine, Two Weeks, September 24. Gastroscopy & Gastroenterology, Two Weeks, September 10. Gastroenterology, Two Weeks, October 22. Dermatology, Two Weeks, October 15. Cardiology (Pediatrics), Two Weeks, November 5.

**RADIOLOGY**—Diagnostic X-Ray, Two Weeks, September 17. Clinical Uses of Radioisotopes, Two Weeks, October 8.

**UROLOGY**—Two-Week Course, October 8. Cystoscopy, Ten Days, by appointment.

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Board of Trustees, New Mexico Physicians' Service: Allan Haynes, M.D., Clovis; W. L. Minton, M.D., Lovington; H. M. Mortimer, M.D., Las Vegas; J. P. Turner, M.D., Carrizozo; U. S. Marshall, M.D., Roswell; J. W. Hillsman, M.D., Carlsbad.

Nominating Committee for 1957: J. A. Evans, M.D., Las Vegas; A. S. Lathrop, M.D., Santa Fe; Robert Friedenberg, M.D., Albuquerque; John Conway, M.D., Clovis; C. Pardue Bunch, M.D., Artesia; Leland Evans, M.D., Las Cruces.

Dr. Sedgwick was recognized for the purpose of introducing new business. He stated that in view of his election to Vice President, he felt it appropriate that he should resign as Councilman from District 6 and recommend that the name of Dr. L. L. Daviet, Las Cruces, be considered to serve out his unexpired term.

The President stated that the House of Delegates accepts with regret Dr. Sedgwick's resignation as a member of the Council and called for nominations for Councilman of District 6 to serve out the unexpired (2 years) term.

Dr. A. D. Maddox nominated Dr. L. L. Daviet for Councilman of District number 6. Dr. E. W. Lander nominated Dr. L. J. Whitaker, Deming, and Dr. J. A. Evans moved that nominations cease which was duly seconded and carried.

Dr. Paul Feil, Deming, stated that Dr. Whitaker had instructed him to decline all nominations in his name and therefore wished to withdraw Dr. Whitaker's name from consideration.

Dr. A. S. Lathrop moved that Dr. Daviet's nomination be unanimous by acclamation which was duly seconded and carried.

There being no further business, the President, Earl L. Malone, M.D., declared the Seventy-Fourth Annual Session of the House of Delegates adjourned.

Respectfully submitted,

LEWIS M. OVERTON, M.D.,  
Secretary-Treasurer.

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## The Book Corner



### New Books Received

New books received are acknowledged in this section. From these, selections will be made for reviews in the interests of the readers. Books here listed will be available for lending from the Denver Medical Library soon after publication.

**Dictionary of Dietetics:** By Rhoda Ellis. N. Y., Philosophical Library, 1956. Price: \$6.00.

**The Menninger Story:** By Walker Winslow. N. Y., Doubleday, 1956. Price: \$5.00.

**New and Nonofficial Remedies, 1956.** Phila., Lippincott, 1956.

**Synopsis of Gynecology:** By Robert James Crossen. 4th ed. St. Louis, Mosby, 1956. Price: \$5.25.

**Diseases of the Skin:** By Richard L. Sutton. 11th ed. St. Louis, Mosby, 1956. Price: \$29.50.

**The Recovery Room; Immediate Postoperative Management:** By Max S. Sadove and James H. Cross. Phila., W. B. Saunders Co., 1956. Price: \$12.00.

**Treatment of Heart Disease; a Clinical Physiologic Approach:** By Harry Gross and Abraham Jexer. Phila., W. B. Saunders Co., 1956. Price: \$13.00.

**Physical Diagnosis:** By Ralph H. Major and Mahlon H. Delp. 5th ed. Phila., W. B. Saunders Co., 1956. Price: \$7.00.

**The Morphology of Human Blood Cells:** By L. W. Diggs, Dorothy Sturm and Ann Bell. Phila., W. B. Saunders Co., 1956. Price: \$12.00.

**Endogenous Uveitis:** By Alan C. Woods. Balt., Williams & Wilkins, 1956. Price: \$12.50.

**Pellomycetis:** By W. Ritchie Russell. 2nd ed. (Edward Arnold, Publishers, Ltd., London). Balt., Williams & Wilkins. Price: \$3.00.

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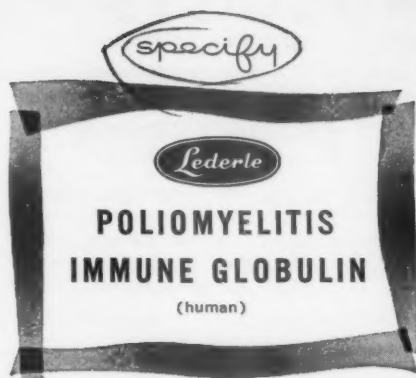
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## OFFICERS, 1955-1956

Terms of Officers and Committeemen expire at the Annual Session in the year indicated. Where no year is indicated the term is for one year only and expires at the 1956 Annual Session.

**President:** Robert T. Porter, Greeley.

**President-Elect:** George R. Buck, Denver.

**Vice President:** Leo W. Lloyd, Durango.

**Constitutional Secretary** (three years): James M. Perkins, Denver, 1957.

**Treasurer** (three years): William C. Service, Colorado Springs, 1956.

**Additional Trustees** (three years): C. Walter Metz, Denver, 1956; Lawrence D. Buchanan, Wray, 1957; Thomas K. Mahan, Grand Junction, 1958; Terry J. Gromer, Denver, 1958.

(The above nine officers compose the Board of Trustees of which Dr. Porter is Chairman and Dr. Lloyd is Vice Chairman for the 1955-1956 year.)

**Board of Counsellors** (three years): District No. 1: Osgood S. Philpott, Denver, 1957; District No. 2: Roger G. Howlett, Golden, 1956; District No. 3: Harry C. Bryan, Colorado Springs, 1958; District No. 4: Paul R. Hildebrand, Brush, 1957; District No. 5: John D. Gillaspie, Boulder, 1957; Vice Chairman: District No. 6: Harvey M. Tupper, Grand Junction, 1958; District No. 7: Charles L. Mason, Durango, 1958; District No.

8: Herman W. Roth, Chairman, Monte Vista, 1956; District No. 9: Scott A. Gale, Pueblo, 1956.

**Board of Supervisors** (two years): William N. Baker, Chairman, Pueblo, 1957; Duane F. Hartshorn, Vice Chairman, Ft. Collins, 1957; Sam W. Downing, Secretary, Denver, 1956; J. Alan Shand, La Junta, 1956; George G. Balderston, Montrose, 1956; Lester L. Williams, Colorado Springs, 1956; Robert A. Hoover, Salida, 1956; Harold E. Haymond, Greeley, 1956; Lawrence W. Holden, Boulder, 1957; Robert C. Lewis, Jr., Glenwood Springs, 1957; Kenneth H. Beebe, Sterling, 1957; James S. Orr, Fruita, 1957.

**Delegates to American Medical Association** (two calendar years): Kenneth C. Sawyer, Denver, 1956; (Alternate, Irvin E. Hendryson, Denver, 1956); E. H. Munro, Grand Junction, 1957; (Alternate, Harlan E. McClure, Lamar, 1957).

**Foundation Advocate:** Walter W. King, Denver.

**House of Delegates:** Speaker, William B. Condon, Denver; Vice Speaker, Carl W. Swartz, Pueblo.

**Executive Office Staff:** Mr. Harvey T. Sethman, Executive Secretary; Mrs. Geraldine A. Blackburn, Executive Assistant; Mr. John W. Pompeili, Executive Assistant; 835 Republic Building, Denver 2, Colo.; Telephone AComa 2-0547.

**General Counsel:** Mr. J. Peter Nordlund, Attorney-at-Law, Denver.

# MONTANA MEDICAL ASSOCIATION

NEXT ANNUAL SESSION: SEPTEMBER 13-15; GREAT FALLS.

## OFFICERS, 1955-1956

Terms of Officers and Committees expire at the Annual Session in the year indicated. Where no year is indicated, the term is for one year only and expires at the 1956 Annual Session.

**President:** George W. Setzer, Malta.

**President-Elect:** Edward S. Murphy, Missoula.

**Vice President:** John A. Layne, Great Falls.

**Secretary-Treasurer:** Theodore R. Vye, Billings.

**Assistant Secretary-Treasurer:** Park W. Willis, Jr., Hamilton.

**Executive Secretary:** Mr. L. R. Hegland, P. O. Box 1692, Office Telephone, 9-2585, Billings.

**Delegate to the American Medical Association:** Raymond F. Peterson, Butte.

**Alternate Delegate to the American Medical Association:** Paul J. Gans, Lewistown.

# NEW MEXICO MEDICAL SOCIETY

75th ANNIVERSARY MEETING: MAY 15, 16, 17, 1957; SANTA FE

## OFFICERS, 1956-1957

Terms of officers expire at the Annual Session in the year indicated. Where no year or term is indicated, the term is for one year only and expires at the 1957 Annual Session.

**President:** Stuart W. Adler, Albuquerque.

**President-Elect:** Samuel R. Ziegler, Espanola.

**Vice President:** James C. Sedgwick, Las Cruces.

**Secretary-Treasurer:** Lewis M. Overton, Albuquerque.

**Executive Secretary:** Mr. Ralph R. Marshall, 223-24 First National Bank Building, Albuquerque; telephone 2-2102.

**Immediate Past President:** Earl L. Malone, Roswell.

**Counsellors** (three years): W. E. Badger, Hobbs, 1957; W. D. Dabbs, Clovis, 1957; W. O. Connor, Jr., Albuquerque, 1958; L. L. Daviet, Las Cruces, 1958; Aaron Margulis, Santa Fe, 1959; Junius A. Evans, Las Vegas, 1959.

**Delegate to American Medical Association** (two years): H. L. January, Albuquerque, 1958; Alternate: Earl L. Malone, Roswell, 1958.

**Board of Supervisors:** A. J. Jensen, Hobbs, Chairman, 1957; W. J. Hossley, Deming, Secretary, 1957; Milton Floersheim, Jr., Raton, 1957; George W. Prothro, Clovis, 1957; A. D. Maddos, Las Cruces, 1958; G. A. Slusser, Artesia, 1958; Louisa Levin, Belen, 1958; Jack Dillahun, Albuquerque, 1958.

**New Mexico Physicians Service:** H. M. Mortimer, Las Vegas, 1957; H. L. January, Albuquerque, 1957; Fred Hanold, Albuquerque, 1957; L. L. Daviet, Las Cruces, 1957; O. C. Taylor, Jr., Artesia, 1957; C. B. Stone, Hobbs, 1957; R. P. Besudette, Raton, 1958; R. V. Seligman, Albuquerque, 1958; Wendell Peacock, Farmington, 1958; Omar Legani, Albuquerque, 1958; Allen Haynes, Clovis, 1959; W. L. Minton, Lovington, 1959; J. P. Turner, Carrizozo, 1959; U. S. Marshall, Roswell, 1959; J. W. Hillman, Carlsbad, 1959; Executive Director, Mr. L. J. LeGrave, 212 Insurance Building, Albuquerque, Phone 3-3188.

# THE UTAH STATE MEDICAL ASSOCIATION

ANNUAL MEETING: SEPTEMBER 5-8; HOTEL UTAH, SALT LAKE CITY

## OFFICERS, 1955-1956

**President:** R. O. Porter, Logan.

**President-Elect:** James Z. Davis, Salt Lake.

**Past-President:** Charles Ruggeri, Jr., Salt Lake.

**Honorary President:** John Z. Brown, Sr., Salt Lake.

**Secretary:** Donald M. Moore, Ogden.

**Executive Secretary:** Mr. Harold Bowman, Salt Lake.

**Treasurer:** Alan P. MacFarlane, Salt Lake.

**Counsellor, Box Elder Medical Society:** James H. Rasmussen, Brigham City.

**Counsellor, Cache Valley Medical Society:** C. C. Randall, Logan.

**Counsellor, Carbon County Medical Society:** L. H. Merrill, Hiawatha.

**Counsellor, Central Utah Medical Society:** John B. Cluff, Richfield.

**Counsellor, Salt Lake County Medical Society:** James F. Orme, Salt Lake.

**Counsellor, Southern Utah Medical Society:** R. G. Williams, Cedar City.

**Counsellor, Uintah Basin Medical Society:** T. R. Senger, Vernal.

**Counsellor, Utah County Medical Society:** R. E. Jorgensen, Provo.

**Counsellor, Weber County Medical Society:** I. Bruce McQuarrie, Ogden.

**Delegate to A.M.A., 1955-1957:** George M. Fister, Ogden.

**Alternate Delegate to A.M.A., 1955-1956:** Eliot Snow, Salt Lake.

**Editor of the Utah Section of the Rocky Mountain Medical Journal, 1957:** R. P. Middleton, Salt Lake.

# THE WYOMING STATE MEDICAL SOCIETY

## OFFICERS 1956-1957

**President:** Joseph Hellewell, Evanston.

**President-Elect:** H. B. Anderson, Casper.

**Vice President:** L. H. Wilmoth, Lander.

**Secretary:** Benjamin Gultiz, Thermopolis.

**Treasurer:** C. D. Anton, Sheridan.

**Delegate to the American Medical Association:** A. P. Sudman, Green River; **Alternate:** B. J. Sullivan, Laramie.

**Executive Secretary:** Mr. Arthur R. Abbey, Cheyenne, P. O. Box 2036.

# COLORADO HOSPITAL ASSOCIATION

**ANNUAL MEETING: NOVEMBER 7-8; BROADMOOR, COLORADO SPRINGS**

## OFFICERS, 1955-1956

**President:** John R. Peterson, Larimer County Hospital, Fort Collins.

**President-Elect:** Sister Mary Jerome, Mercy Hospital, Denver.

**Vice President:** Hubert Hughes, General Rose Memorial Hospital, Denver.


**Treasurer:** M. A. Morris, Denver General Hospital, Denver.

**Executive Secretary:** Richard P. Mac Lelsh, Denver.

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**Trustees:** Robert A. Pontow (1956), University of Colorado Medical Center, Denver; Roy Prangley (1956), St. Luke's Hospital, Denver; Magr. John B. Mulroy (1956), Catholic Charities, Denver; Roy Anderson (1957), Presbyterian Hospital, Denver; Harry Clark (1957), Southwest Colorado Memorial Hospital, Cortez; Elton A. Boese (1957), Alamosa Community Hospital, Alamosa; Louis Linswood (1958), National Jewish Hospital, Denver; Charles K. Levine (1958), Beth Israel Hospital, Denver; C. F. Fieldon, Jr., (1958), Memorial Hospital, Colorado Springs; Louis I. Miller, M.D. (ex-officio), Colorado Hospital Service, Denver.

**Delegates:** Harley E. Rice, Porter Sanitarium and Hospital, Denver; Henry H. Hill, Alternate, Weld County General Hospital, Greeley.



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## Index to Advertisers

|                                       | Page      |  | Page                                  |                               | Page                        |
|---------------------------------------|-----------|--|---------------------------------------|-------------------------------|-----------------------------|
| American Medical & Dental Association | 772       | Hyde Pharmacy                              | 774                                   | Schering Corporation          | 676-677, 696-697, 741-742   |
| Ames Company, Inc.                    | Cover III | Kincaid Pharmacy                           | 774                                   | Schleffellin & Company        | 773                         |
| Ayerst Laboratories                   | 751       | LK Professional Pharmacy                   | 767                                   | Schmid, Julius                | 679                         |
| Bernon, G. & Company                  | 680       | Lakeside Laboratories                      |                                       | Scott Surgical                | 738                         |
| Bob's Place                           | 773       | Las Encinas Sanitarium                     | 675, 752, 758                         | Searle, G. D. & Company       | 729                         |
| Bonita Pharmacy                       | 774       | Lederle Laboratories                       | 776                                   | Shadford-Fletcher             | 769                         |
| Brown & Williamson                    | 690       |  | 724-725, 773                          | Shirley-Savoy Hotel           | 756                         |
| Burroughs-Wellcome                    | 771       | Lilly, Eli & Sons                          | Cover I, 698                          | Smith, Kline & French         | 685, 691-692, 747, Cover IV |
| Cambridge Dairy                       | 755       | Lubin Drugs                                | 774                                   | Southard School               | 772                         |
| Carlson-Frink Dairy                   | 772       | Merchants Office Furniture                 | 776                                   | Squibb, E. R. & Sons          | 693                         |
| Case, G. M. Laboratories              | 758       | Merck Sharp & Dohme, Inc.                  |                                       | Stanley Hotel                 | 749                         |
| Children's Hospital                   | 767       |  | 675, 687, 689, 694-695, 703, 745, 761 | Stapleton, H. C. Drugs        | 756                         |
| Clba Pharmaceutical                   | 754       | Mercy Hospital                             | 767                                   | State of Montana              | 773                         |
| City Park Dairy                       | 770       | Metropolitan Building                      | 734                                   | St. Mary's Hospital           | 765                         |
| Classen Nursing Home                  | 757       | Mount Airy                                 | 755                                   | Stodghill's Imperial Pharmacy | 755                         |
| Cocks-Clark Engravers                 | 762       | Mountain States Securities & Accident      | 777                                   | Taylor, M. F. Laboratories    | 767                         |
| Colorado Artificial Limb Company      | 769       | Newton Optical Company                     | 768                                   | Technical Equipment Co.       | 678                         |
| Colorado Hospital Service             | 744       | Park Floral                                | 757                                   | Telephone Answering Service   | 768                         |
| Colorado State Bank                   | 757       | Parke, Davis & Company                     | Cover II, 673                         | Thornton, George R.           | 752                         |
| Conny's Motor Company                 | 768       | Pfizer Laboratories                        | 681, 733                              | Trowbridge Training School    | 768                         |
| Cook County Graduate School           | 766       | Physicians Casualty                        | 753                                   | Udry Insurance Agency, Inc.   | 738                         |
| Corn Products                         | 682       | Picker X-Ray Corporation                   | 772                                   | U. S. Brewers Foundation      | 737                         |
| Cummings Pharmacy                     | 774       | Plains Dairy System                        | 766                                   | Van's Pharmacy                | 774                         |
| Deep Rock Water                       | 764       | Presbyterian Hospital                      | 764                                   | Wallace Laboratories          | 731                         |
| Denver Optic Company                  | 755       | Professional Men's Association of Colorado | 684                                   | Wantada                       | 773                         |
| Dorr Optical Company                  | 767       | Publishers Press                           | 762                                   | Weiss, Paul, Optical          | 756                         |
| Earnest Drugs                         | 774       | Republic Building                          | 778                                   | Whittaker's Pharmacy          | 774                         |
| Emory J. Brady Hospital               | 770       | Republic Drug                              | 765                                   | Winthrop Laboratories         | 746                         |
| Fairhaven Maternity Service           | 767       | Riker Laboratories                         | 683                                   | World Insurance               | 685                         |
| Foot-so-Port Shoe Co.                 | 769       | Roedel's Drug                              | 769                                   | Wyeth Laboratories            | 719                         |
| Gibson Surgical                       | 764       |  |                                       |                               |                             |
| Hoffman-LaRoche                       | 759, 760  |  |                                       |                               |                             |

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